McGill University

Follow-Up Study of Patients Discharged From A Psychiatric Hospital

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for

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by

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PREFACE

The writer acknowledges with gratitude the constant assistance and guidance of Mrs. P. Poland and Mrs. J. Powles Smith of the Social Service Department of the Allan Memorial Institute of Psychiatry. Thanks is due to Dr. D. Ewen Cameron for his kind permission to make this study in the Allan Memorial Institute and for permitting the use of the hospital records and further contact with the selected patients. Thanks is also due to the psychiatrists, who were continuing to see some of these patients, for their kind permission to interview their patients.

The writer is also grateful to Miss E. R. Young, and Miss B. Judkins of the McGill School of Social Work for their unfailing interest, encouragement and helpful criticism of the study.

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CHAPTER ONE

INTRODUCTION

Follow-up implies a renewal of contact for the purpose of further study; a scientific method used for testing theoretical formulations. In the many social sciences dealing with human beings, the hypotheses concerning cause and effect of human behaviour are continually changing. These hypotheses must be tested if progress is to be expected in the understanding, prediction and control of illness and maladjustment. Follow-up studies offer primary source material, and as such provide a wider scope for study than secondary source material. The results of follow-up studies may not be conclusive. However, they contribute to a social science by increasing knowledge in certain areas and by indicating areas where further studies are needed.

A perusal of published studies in the field of psychiatry indicates a dearth of generalized follow-up studies of all patients discharged from a psychiatric hospital. Some studies have been made within limitations of diagnostic groups, age groups, etc. Studies of this kind increase our knowledge and understanding of specific areas in the field of psychiatry. They do not provide any indication of what results can be expected from treatment for all patients in a given hospital at a stated time.

With the ever increasing tempo and anxiety of our post-war era, there has developed a steadily increasing interest in the individual and his adjustment. The realization of the rights of the individual to the elements of a satisfying adjustment has served to emphasize the need for mental hygiene programs and psychiatric treatment. This has led to an increasing demand for psychiatric treatment far exceeding the numbers of personnel available. It is important, therefore, that the best possible use be made of all personnel in the field of psychiatry. One way in which this can be done is through follow-up studies which increase knowledge for more effective selection and treatment of patients.

This would seem to be an opportune time, therefore, to undertake a follow-up study of patients discharged from a psychiatric hospital. The Allan Memorial Institute of Psychiatry[1] decided this was an opportune time to take stock of the benefit patients have received through hospitalization because it was a relatively new hospital where no previous follow-up study had been done to test treatment results. The A. M. I. consequently requested a student social work thesis on this project to assist in the study in an effort to help determine the most effective methods and techniques of approaching the subject. The writer was further prompted to undertake this study because of her interest in what happened

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[1] Hereafter referred to as A. M. I.

to patients following psychiatric treatment.

Since this is the first project in a generalized follow-up study of patients at the A. M. I., it is a new venture which may give some answers to techniques and methods for the long term program. It may indicate areas where further help would effect increased benefit to the patient.

Psychiatric hospitals may be organized under state or private auspices and are usually established to help in the cure of mental illnesses. Psychiatric hospitals may be operated on a voluntary or a commitment basis. Those which operate on a voluntary basis do not as a rule take patients who will require as long a period of hospitalization as those patients who are sent to a hospital on a compulsory basis.

The hospital in which this study was undertaken is known as the A. M. I. It is a voluntary hospital and the first one of its kind in the Montreal area where patients, who are not ill enough for commitment to a mental hospital, can be hospitalized. It is an in-patient unit of the Royal Victoria Hospital[1], opened in 1944 for three main purposes: the provision of intensive therapy, teaching opportunities, and research. The first two categories fell under the auspices of the R. V. H., the third, under McGill University.[2]

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[1] Hereafter referred to as R. V. H.

[2] Burns, M., "The Allan Memorial Institute of Psychiatry," Social Worker, December, 1946.

The hospital unit is made up of one male ward, two female wards and a day ward. Patients in the day ward come in for treatment during the day, and return home at night. Admission to the hospital is on a selective basis, as provision is made only for cases which can be treated in a short term of approximately six weeks. Patients are admitted for private, semi-private, or public ward care. Treatment is by psychotherapy, shock therapy and other current forms of treatment.

The A. M. I. is located on the slopes of Mount Royal, overlooking the city of Montreal. It is surrounded by spacious grounds, with the natural park of the mountain in the background. This gives an atmosphere of remoteness from the tempo of city life. These grounds are conducive to pleasant and relaxing outings for the patients.

The A. M. I. has the capacity for 65 patients, 43 in-patients and 22 day patients. Criteria for admission contain no limitations as to race or creed, but there is a selection in terms of age. Only adult patients, defined as persons over sixteen years of age, are admitted for treatment.

The activities which are available to the patients are utilized in accordance with time available, and planned in accordance with the treatment they are receiving. Group therapy, although not compulsory, is strongly urged by the doctors, and most patients attend. Groups are held Monday

through Friday by the head nurse on each ward. Didactic[1] groups with a doctor are held twice a week on each ward. A discharge group is held weekly under the leadership of a psychiatrist and a psychiatric social worker. These groups are purely intellectual and, as such, they are not designed to cure patients. They do serve a therapeutic purpose, however, through a suggestive and supportive type of therapy.

Great emphasis is laid upon the desirability of the patients mixing with the other patients, of entering into all the social and recreational activities. Evening activities at the A. M. I. include weekly movies and instruction in ballroom dancing. One night a week the Junior League provides recreational opportunity in the nature of table games and dancing. Once a week square dancing is available under the leadership of a student group worker.[2]

Daytime activities include occupational therapy and finger painting. Patients are encouraged to go for walks either alone or with a member of the nursing staff. As they draw near the time of their discharge, many patients are urged to visit relatives or friends, to make trips downtown, or they may be given an opportunity to spend a trial weekend

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[1] Didactic used here is defined as, a method of teaching, where a lecture is followed by discussion.

[2] The square dancing program was initiated in November, 1949. The patients included in this study, therefore, did not have the opportunity to participate in this activity.

at home. Many patients are discharged from a hospital ward to the day ward as a gradual step toward readjustment in the community.

This study set out to assess the effectiveness of treatment in returning to the community a person who is better adjusted than he was at the time of admission. The study will be done from the social worker's point of view, comparing symptomology and social adjustment. Since the patients who were included in this follow-up study had been in hospital at a time when the Social Service Department of the A. M. L was short staffed and did not participate actively in the treatment process, the role of the social worker will not be studied.

In this study, no attempt can be made to evaluate treatment as this lies within the specialty of the doctor. Neither can we attempt to prognosticate the condition of the patients in months to come. This study can only attempt to indicate the condition of the patients from 4 to 7 months after discharge from hospital, relative to their condition on admission.

Since the follow-up interviews are done by a social case worker, this imposes certain limitations. No psychiatric diagnosis and evaluation of the patient's condition at follow-up can be made by the social worker, and the patients have not been seen at this time by the psychiatrist. The social worker can only discuss the content of one interview with each dis-

charged patient and the observed behaviour of each patient with respect to the use he is able to make of his environment. This imposes a further limitation since one interview provides a limited understanding of the patient's condition. Moreover, we have only the patient's statement of how he feels since no attempt was made to see friends or families for additional information.

The progress of these patients will be studied through the follow-up interviews to determine their present condition, relative to admission status and to a normal adjustment. This will limit the picture since we have only the patients' statements and feelings in this respect and the writer's observations of their behaviour and environment. This will further be colored by the patients' positive or negative identification with the hospital.

An analysis of the follow-up process will be made in terms of each patient's response to renewal of contact, his attitude to the hospital, and a comparative analysis of present adjustment in relation to admission status.

In this study, the term "status" will refer to the condition of the patient in terms of symptoms presented and social adjustment with respect to family, friends, work and recreation. The basic questions the study will attempt to answer are:

1. How does the status of the patients on admission differ

from their status approximately 4 to 7 months after discharge?

2. How are the patients functioning now in relation to what is considered normal?
3. How useful is the follow-up letter system as a means of indicating the effectiveness of treatment at the A. M. I.

The major emphasis of the study is concerned with the first two questions. The third question, concerning the method of follow-up, will receive minor attention.

In order to indicate the change in status of the patients at the time of their follow-up interview, as compared with their admission status, it was necessary to devise some means of indicating the direction and nature of the changes which had taken place. The analysis will therefore develop along two separate planes, namely:

1) a comparison of the patient's condition at follow-up with his condition at time of admission.
2) a comparison of the patient's condition at follow-up with four degrees of adjustment relating to a hypothetical "normal" adjustment.

Since the terms of comparison in a study of this type must be broad, the first plane of comparison will be described as, "better," "the same" or "worse" when interviewed by the writer as compared with the patient's status on admission to hospital. These three levels of comparison are based on inferences of the writer as gained by observation of behaviour and environment and what the patient said concerning how

he felt. For the purposes of this study the three levels are defined as:

A. Better--The patient's anxiety and symptoms are improved and he is functioning on a more adequate level than when admitted to the hospital.

B. The Same--The patient's anxiety and symptoms are not improved and he is functioning on approximately the same level as when admitted to the hospital.

C. Worse--The patient's anxiety and symptoms are increased and he is functioning on a less adequate level than when admitted to the hospital.

The second plane, which will constitute the major emphasis of the analysis, will be indicated through a comparison of the follow-up status with what might be considered a normal adjustment. For terms of comparison of status at follow-up, relative to normal adjustment, the writer has borrowed a scale from a follow-up study done by Stanley E. Crawfort,[1] which involves four levels, viz:

A. Normal Adjustment--efficient and happy functioning with minimum of anxiety and relative absence of symptoms.

B. Adequate Adjustment--some areas of disturbance which interfere with maximum happiness and efficient performance.

C. Poor Adjustment--emotional and social impairment reflected in symptoms, anxiety and poor performance.

D. Not Adjusting--severe impairment of emotional and social functioning. Intensive treatment or institutionalization necessary.

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[1] Crawfort, S., Examination of Status at Discharge and Follow-up of 9 Children, All of Whom Were Treated by the Same Psychiatrist When Hospitalized at the N. Y. State Psychiatric Institute and Hospital. Submitted for M. S. W. Degree, N. Y. School of Social Work, (Columbia University, N. Y., 1946 or 1947).

For the purpose of this study we will consider those patients who come within the first two categories to be making a satisfactory adjustment. Those patients, who come within the last two categories, are here considered to have made an unsatisfactory adjustment. This will serve to indicate the degree of adjustment in respect to the broader terms of adjustment at follow-up relative to status on admission.

The study involves the analysis of 15 interviews and the hospital records of patients who were discharged during one month, and who were followed-up 4 to 7 months after discharge. The writer selected for study all patients who were residents of Greater Montreal, and who were discharged from the A. M. I. during the month of October, 1949. This choice was made partly because this was the first available group in the newly established follow-up system at the A. M. I. Only patients in the Montreal area were chosen because interviews could not be arranged with patients who lived outside of Greater Montreal. Eighteen patients came within these defined limits. This number was further narrowed by the death of two patients and by one patient who refused to be interviewed.

The material for the study was gathered from the hospital psychiatric records, follow-up interviews, and replies to follow-up letters. The primary materials from the follow-up interviews and the follow-up letters were gathered according

to a schedule.[1] The secondary materials were selected from the admission and discharge summaries of the hospital records and were collected according to a document schedule.[2] The intervening record material was found to be of little value. This imposed a serious limitation as we do not get a picture of the patient's reaction to the hospital and treatment, nor his progress during hospitalization. These data would be important in determining the extent to which the patient's insight or lack of insight, his understanding of his problem and his reaction to such enabled him to use treatment.

A further limitation is imposed by the unevenness of the psychiatric records. All the patients were treated during hospitalization by resident psychiatrists. This means that the records are written by persons who are in the process of training as psychiatrists and that they are in the learning process with varying degrees of skill.

The schedule proposed by the A. M. I. concerning its follow-up system of letters gave direction for the beginnings of this study. The general policy of the follow-up system was outlined in a memorandum by Dr. D. Ewen Cameron, Director of the A. M. I., on September 23rd, 1949.[3] This established

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[1] Schedule, see Appendix p. 125.

[2] Document Schedule, see Appendix p. 125.

[3] Appendix p. 118.

that personalized letters would be sent to all patients at periods of three months and six months after discharge, and thereafter at yearly intervals from time of discharge. The service would be initiated on October 1st, 1949, under the direction of the social service department with consultation of one of the residents.

Mrs. P. Poland, chief psychiatric social worker at the A. M. I., initiated the service with Dr. C. H. Cahn as consultant. The procedure for the follow-up system was established as follows:[1] no letters would be sent to patients who had been committed or discharged against advice, since replies could not be expected from them; also private patients of Dr. Cameron, who were still being seen by him, could not be sent a letter since the letters were signed by him. The content of the letters would consist of three parts. In the first place, a brief explanatory introduction was given. Secondly, general questions were asked which related to the patients' hospital experience. Thirdly, specific questions directed to the patients with regard to their own individual problems were asked.

In January, follow-up letters[2] were sent to the patients discharged during October, 1949, except for those patients

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[1] Appendix p. 120

[2] Appendix p. 123

who fell within the excluded categories previously mentioned. The number receiving letters, and who came within the scope of the writer's study totaled 16. In addition to this group there were 2 patients who were still being seen by Dr. Cameron.

Since a number of the patients were continuing treatment with private psychiatrists, the latter were contacted for permission to interview their patients. Of the total number, 5 patients were continuing treatment privately and the consent to interview them was received from all the doctors concerned.

The writer felt that the patient would be more at ease if he were interviewed in his own home rather than at the hospital. Also, it would provide an opportunity for observation of the environment to which the patient had returned and, in the case of many, it would give the writer some indication of his adjustment to the environment. It was therefore decided that interviews would be arranged by means of home visits unless the patient expressed a preference for an office interview.

Replies to follow-up letters were received from 6 of the 18 patients and appointments for interviews were subsequently arranged with 5 of these by telephone. One refused to be seen. With respect to the remaining 12, consultation with the doctors who had treated the patients in hospital indicated that in two

cases further approach would be advisable by telephone. In one case because of the low level of intelligence, and in the other case because of the environmental situation, a telephone call was felt to be the best approach. In one case the doctor arranged the follow-up interview, and in another case further contact was made by telephone since the follow-up letter had gone out late through an oversight.

The remaining eight patients were sent a second letter.[1] This letter referred to the first one, indicating a continued interest by the hospital in the patient's progress and the purpose of the letter. It further indicated an understanding by the hospital personnel of the difficulty in answering a letter; it suggested that an interview might be easier, and it gave an appointment for such a contact. As a result of these letters all but two patients were subsequently seen. These two patients died before interviews were arranged.

Following these contacts for follow-up interviews, 15 patients were seen. Of this number, 13 patients were visited in the home and two were seen in office interviews at the A. M. I. The two office interviews were held because the patients were staying out of town, and appointments were arranged when they came to the hospital for follow-up therapy with their doctors.

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[1] Sample copy of second Follow-Up Letter in Appendix, p. 124

With these points in mind the study will include six chapters which will proceed in the following order. As an introduction to the analysis of the data, Chapter II will give a description of the fifteen patients. This will include an analysis of the age, sex, marital status, education, occupation, intelligence, onset of illness, diagnosis, and length of hospitalization of the fifteen patients. The following three chapters provide an analysis to indicate the effectiveness of treatment of persons who later had returned to the community. First, an analysis will be made of record and interview material from the point of view of comparing the condition of the patients on admission with their condition on follow-up, relative to a normal adjustment. This is followed by an analysis of the present social adjustment of the patients. This will take into consideration the patients' present adjustment to family living insofar as it can be learned from the interviews. The last of these chapters will discuss the patients' follow-up adjustment to their friends, work and recreation as gained from the interviews.

The following chapter will take into consideration the second emphasis of the study, namely, a consideration of the usefulness of follow-up letters. This will include a discussion of the patients' attitude to the hospital as indicated in the follow-up interviews, and an analysis of the patients' responses to renewal of contact with the hospital, as represented

by the writer.

Chapter VII will give a summary of the material which has been presented, together with conclusions of the effectiveness of treatment at the A. M. I. and the usefulness of the Follow-Up letters.

CHAPTER TWO

STATISTICAL ANALYSIS OF THE FIFTEEN PATIENTS

Some understanding of the personal and social characteristics and illness experiences of the 15 patients forms an interesting introduction to an analysis and assessment of the patients' adjustment which will be considered in the following chapters. A quantitative analysis of these data will give some indication of the basic capacities and assets of the patients. Moreover, it will provide some knowledge of the individuals as patients.

While the material is fragmentary and the number of cases too small to be of statistical importance, the significance of many of these factors will emerge later. A more complete analysis, than is possible in this study, would be valuable in establishing criteria for the selection of patients for treatment.

In the following description of the patients we will consider age, sex, marital status, education, occupation, financial status, intelligence level, first recognition of difficulty by patient or others, length of hospitalization, and, finally, the diagnosis.

At the time of admission to the hospital these 15 patients ranged in age from 20 to 61 years with the median age being 37 years. From Table I it can be seen that the greatest number of patients fell in the lowest age group with the greatest number of female cases coming in this group. The

greatest number of male patients fell in the 30--39 year age group. The majority of all patients, or 60 per cent, were between the ages of 20 and 40 years. After the age of 49 years there was a sharp drop in the number of cases in both male and female patients. Hence, the group is composed largely of individuals in early adulthood who normally would be in the period of greatest mental vigor and productivity.

Of the 15 cases studied, 10 were women patients and five were men patients. This ratio of two to one correlates with admission figures in this hospital. When the A. M. I. was first opened, it was made up of two male and two female wards. However, the number of female admissions was found to exceed male admissions and one male ward was therefore turned into a day ward. The higher percentage of female patients is significantly different from admission and discharge rates in psychiatric hospitals generally. Dr. Lowrey states that, ". . . the admission rate for males is disproportionately higher than for females. . . discharge rates are substantially higher for males."[1] Dr. Lowrey, in speaking of the psychoneuroses says, " . . . there is a general impression that they occur considerably more frequently in females than in males, but this may be doubted." Since the majority of the patients were diagnosed as neuroses, it is possible that the high proportion

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[1] Lowrey, L. G., Psychiatry for Social Workers, New York, (1950), p. 25.

of neurotic patients in this study could account for the significant difference in male and female patients. However, with such a small selected sample, little significance can be attached to the higher proportion of female patients.

Table I - Sex, Age and Marital Status Classification of the 15 Patients at Admission to A. M. I., Montreal, 1949.[a]

		MALE			FEMALE		
AGE IN DECADES	TOTAL	MARRIED	SINGLE	WIDOWER	MARRIED	SINGLE	WIDOW
TOTAL	15	3	2	-	5	4	1
20-29	5	-	1	-	2	2	-
30-39	4	2	-	-	1	1	-
40-49	4	1	-	-	2	1	-
50 & Over	2	-	1	-	-	-	1

[a]Details regarding institution, place and date will be omitted for later tables in the series.

As regards marital status, the majority of the patients, namely, eight, were married, six were single and one was a widow. None of the patients was divorced or separated. This might be significant in view of the increasing high divorce rates.

From Table II, the occupations and educational achievement of the 15 patients can be seen. Concerning the educational

achievement of the patients, it can be seen that seven had more than grammar school education. Of these, two were university graduates and five had some high school. In the last group were three persons who had specialized courses following high school education. Only one patient had no formal education and four had some grammar schooling. In three cases, the educational level was not known.

With respect to occupation, it can be seen in Table II that there were four professional people. Of these, two were university graduates, one had some high school plus special courses, and in one case the educational achievement was not stated. In the latter case, however, the patient was an engineer and therefore must have been a university graduate. This would indicate that three out of four of the professional people were university graduates and that all had more than high school education.

There was one skilled worker in the group. This patient had some high school plus a special course. In the semi-skilled group there were two patients. Concerning the educational achievement of this group, one person had some high school education and one had some grammar schooling. With respect to the non-skilled workers, of which there were two, one patient had no formal education and in one case the education was not known. This would indicate that the occupational distribution became less skilled with the drop in the

educational level of the patients, the professional group having the most education and the non-skilled workers the least education, with a gradual lowering of the educational level.

Table II - Education and Occupation Classification of the 15 Patients at Admission.

EDUCATIONAL ACHIEVEMENT	TOTAL	OCCUPATION				
		PROFESSIONAL	SKILLED	SEMI-SKILLED	NON-SKILLED	HOUSEWIFE
TOTAL	15	4	1	2	2	6
UNIVERSITY GRADUATE	2	2	-	-	-	-
SOME HIGH SCHOOL PLUS SPECIAL COURSE[a]	3	1	1	-	-	1
SOME HIGH SCHOOL[b]	2	-	-	1	-	1
NO FORMAL EDUCATION	1	-	-	-	1	-
SOME GRAMMAR SCHOOL[c]	4	-	-	1	-	3
EDUCATION UNKNOWN	3	1	-	-	1	1

[a]Refers to at least 1 year of High School plus special courses.

[b]Refers to at least one year of High School.

[c]Refers to at least one year of grammar school.

With respect to the housewives, five were married and one was a widow living with her son. The occupations of the husbands included one professional, one had his own electrical business, one was associated with a large business concern controlled by his family, one was a non-skilled laborer and in one case the husband's employment was not known. The widow's son was a semi-skilled laborer.

None of the patients was in receipt of relief and the economic level was adequate in the majority of the cases. The majority of the patients or husbands of the patients were employed in so-called "white collar" jobs, indicating an average social and economic status. Socio-economic status may not be an important factor in emotional stress since good family relations may compensate to a large extent for low socio-economic status. However, as Dr. Coleman states, ". . . other things being equal, higher socio-economic status usually provides a more healthy and stimulating environment. . ."[1] This would suggest that the socio-economic status of the majority of the patients was an asset in treatment.

Psychological tests indicating the level of intelligence were available for nine patients. Of this number seven were of average or above average intelligence. The remaining two were of dull normal range. Of the six patients whose intelligence level was not known, three indicated above average

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[1] Coleman, J. C., Abnormal Psychology and Modern Life, Chicago, 1950.

intelligence because of educational and occupational achievements. In one case the patient was a medical doctor, one was a chemical engineer, and one a secretary. The remaining three for whom there was no intelligence rating, included a clerical worker, a housewife, and an elevator operator. Taken together this information suggests that the majority of the patients were of average or above average intelligence. This would also indicate that the majority were intellectually capable of taking an active role in therapy.

It is recognized that early environmental influences are of great importance in shaping personality. It is also well recognized that unhealthy developmental trends predispose an individual to later maladjustment and breakdown. This would suggest that the patients under study may have had unhealthy personality development from their early years. However, they had been able to maintain some degree of stability until the breakdown which led to hospitalization. Any cursory discussion of onset of difficulty, therefore, indicates little but the first recognition by patient, family, or friends of the existence of maladjustment. As such, it provides some indication of the duration of acute maladjustment and amenability to treatment.

From Table III it can be seen that the majority of the patients, or 10, reported that the onset of symptoms as less than two years prior to admission to hospital. Of these,

eight reported symptoms for less than one year. Five patients reported symptoms for more than five years. Dr. Rogers says:

> Both clinical experience and a certain amount of research evidence indicate that the highly unstable individual . . . is not a good risk for psychotherapy, or indeed for any type of treatment approach developed to date.[1]

Since it is presumed that the patients were able to cope with their situations prior to breakdown and onset of symptoms, the relatively short duration of symptoms of the majority of the patients would suggest amenability to treatment.

Table III - Reported Onset of Symptoms Classification of 15 Patients on Admission.

REPORTED ONSET OF SYMPTOMS	NUMBERS
TOTAL	15
under 6 months	5
6 months--1 year	3
1--2 years	2
over 5 years	5

From Table IV it can be seen that the diagnoses of the 15 patients included eight neuroses, six psychoses, and one alcoholism. The average length of hospitalization for all patients was seven weeks. The greatest number of patients,

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[1] Rogers, Dr. C. R., Counselling and Psychotherapy, (Cambridge, 1942).

namely five, were hospitalized for the longest period of time. The majority of the patients, namely nine, were hospitalized for less than eight weeks. The majority of those patients with a diagnosis of neurosis were hospitalized for less than eight weeks. On the other hand the psychotic patients tended to be hospitalized for a longer period of time. The majority of those patients with a diagnosis of psychosis were in hospital for over eight weeks. The one patient suffering from alcoholism was hospitalized for less than four weeks. This would suggest that psychotic patients require longer periods of hospitalization and treatment than do the neurotic patients.

Table IV - Diagnosis and Length of Hospitalization Classification of 15 Patients at Discharge.

LENGTH OF HOSPITALIZATION	TOTAL	DIAGNOSIS		
		NEUROSES	PSYCHOSES	ALCOHOLISM
TOTAL	15	8	6	1
UNDER 4 WEEKS	3	2	-	1
4 - 6 WEEKS	3	1	2	-
6 - 8 WEEKS	3	3	-	-
8 - 10 WEEKS	1	-	1	-
10 - 12 WEEKS	5	2	3	-

In summary, the group of 15 patients under study, is made up of ten female and five male patients, ranging in age from

20 to 61 years with the median age being 37 years. Eight of the patients were married, six were single, and one was a widow. The majority of the patients or husbands of the patients were employed in jobs which indicated an average social and economic status. From the psychological tests and educational achievement of the patients, it was shown that the majority were of average or above average intelligence. The duration of illness in the majority of the patients was less than one year. The patients were hospitalized for an average period of seven weeks, with the psychotic patients being hospitalized for a longer period of time than the neurotic patients. The majority of the patients, or eight, were neurotic, six were psychotic, and one was an alcoholic.

With some understanding of the patients as a group, the following chapters will provide an analysis of the patients' adjustment at follow-up with respect to symptomology, family, friends, work and recreation.

CHAPTER THREE

ADJUSTMENT OF PATIENTS WITH RESPECT TO SYMPTOMS

In the preceding chapter we have seen that the group of patients under consideration is composed largely of individuals in early adulthood, the majority of whom had reached an average level of achievement in the past as noted in their educational, marital and employment status. An evaluation of the basic assets and capabilities of the individual is important in determining adjustment. Dr. Hinsie says, " . . . patients are helped by psychotherapy and other measures. Those who are helped are the ones who have had many good social assets to begin with . . ."[1] We could assume, therefore, that this was a group of patients who would be able to make fairly adequate use of treatment.

> The results of our therapeutic methods are meager compared with the great amount of endeavor, thinking and hard work invested. The radical cure for mental disorder has not yet been found, except for those early stages when the process is wholly reversible. Otherwise, one can only alleviate; one can only help people understand themselves; one can help them live with their difficulties; and one can remove harmful and painful symptoms.[2]

As Dr. Frankl has stated, there are no cures for psychiatric disorders. Treatment is therefore directed toward alleviating symptoms and helping the individual to make a better adjustment to his difficulties. An assessment of therapeutic results must consequently consider whether the

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1 Hinsie, L. E., Understandable Psychiatry, New York, (1948)

2 Frankl, G., "The Dilemma of Psychiatry Today", Mental Hygiene, (October, 1949), Vol. XXXIII, No. 4.

patient's symptoms have been helped and whether he has been able to make a more satisfactory social adjustment than he did before treatment.

While it is recognized that many factors influence treatment results, it is not the purpose of this study to evaluate treatment. This study will attempt to indicate the effectiveness of treatment in terms of alleviation of symptoms and social adjustment as the patients are seen from four to seven months following discharge from hospital. The social adjustment will be discussed in the two following chapters in relation to adjustment to family, friends, work and recreation. The alleviation of symptoms will be considered with respect to the terms described in Chapter I. These terms, it will be recalled, are:

1. An estimate is made of the patients' status on follow-up as compared with admission status in one of the following terms, namely, better, the same, or worse.[1]
2. The patients' status on follow-up will be assessed, relative to a normal adjustment, and each case will be classified in terms of one of the following levels of adjustment,[2] namely, normal adjustment, adequate adjustment, poor adjustment, not adjusting.

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[1] Supra p. 9

[2] Supra p. 9

Fifteen patients, discharged during October, 1949, were followed-up. Of these, 14 patients were better four to seven months after discharge compared to their condition on admission to hospital. One patient was found to be the same as when he was admitted to hospital. None of the patients was worse at the time of follow-up compared to their condition on admission to hospital.

Of the 14 patients who were improved, one person had been hospitalized for medical reasons following discharge from the A. M. I., and she felt her improvement was due to this and not to treatment at the A. M. I. The remaining 13 patients felt that hospitalization had helped them. One patient, who was better on follow-up compared to admission status, was admitted to hospital with numerous complaints. These included weakness, tiredness, anxiety, tension, poor sleep, strange sensations in her stomach and difficulty with her vision. She was unable to do her housework and she had attempted suicide prior to admission to hospital. Diagnosis was severe anxiety hysteria with reactive depression. When interviewed five months after discharge from hospital, the patient was feeling much better. She was eating and sleeping well. She no longer felt weak nor tired and she was able to do her housework without difficulty. Her only complaint was with her stomach. She still had the strange sensations in her stomach but this was not seriously affecting her everyday living.

The one patient who was found to be the same at follow-up compared to his admission status was an alcoholic. For thirteen years he had been consuming large quantities of alcohol daily. He was admitted to hospital for clinical investigations and preparation for antabuse therapy. He was then discharged to receive antabuse therapy on an out-patient basis. He followed this course of treatment for a few weeks. At that time he decided not to return because he was doing so well that he felt he could carry on himself. The patient managed satisfactorily for two months and then reverted to drinking. When followed-up six months after discharge from the hospital, the patient was drinking to the same extent as before hospitalization.

These broad terms of comparison, previously mentioned as the writer's terms, indicate that 14 patients benefited by hospitalization and treatment. The one remaining case did not receive any benefit but he was no worse than when he was admitted to hospital.

While this information gives us a general picture of the direction of change, it does not indicate the status of the patients at the time of follow-up. A comparison will therefore be made of the patients' condition at the time of follow-up with a normal adjustment as described in Chapter I.[1] This will serve to provide a better understanding of the patients'

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[1] Supra, p. 9

adjustment at time of follow-up.

From Table V it can be seen that the status of the 15 patients at the time of follow-up indicated that one was making a normal adjustment, eight an adequate adjustment, four a poor adjustment, and two were not adjusting. For the purposes of this study, the writer has considered the first two categories to be a satisfactory adjustment, and the latter two categories to be an unsatisfactory adjustment. This would, therefore, indicate that nine patients, or 60 per cent, were making a satisfactory adjustment and six patients, or 40 per cent, were making an unsatisfactory adjustment.

Table V - Adjustment of 15 Patients Classified According to Diagnosis at Discharge.

ADJUSTMENT OF PATIENTS 4-7 MONTHS AFTER DISCHARGE	DIAGNOSIS			
	TOTAL	NEUROSES	PSYCHOSES	ALCOHOLISM
TOTAL	15	8	6	1
NORMAL ADJUSTMENT	1	-	1	-
ADEQUATE ADJUSTMENT	8	6	2	-
POOR ADJUSTMENT	4	1	2	1
NOT ADJUSTING	2	1	1	-

Of those patients who were making a satisfactory adjustment, it can be seen from Table V that six were diagnosed as neuroses and three as psychoses. Those patients making an unsatisfactory adjustment included two with diagnosis of neurosis, three of psychosis, and one of alcoholism. In other words, the majority, or six, of the patients diagnosed as neurosis were making a satisfactory adjustment at the time of follow-up; whereas only half, or three, of those patients diagnosed as psychosis were making a satisfactory adjustment. The one case of alcoholism was making an unsatisfactory adjustment.

A great deal of the success in treating a patient depends on the selection of method of treatment appropriate to the individual. Psychiatric therapy is highly individualized, and this is necessitated by the fact that every patient is an individual with his own particular experiences, temperament and goals. Therefore, treatment methods cannot be generalized without the risk of failure in many cases. Treatment methods in this study cannot be evaluated as this lies within the specialty of the psychiatrist and could be the area of another study. However, the writer would like to discuss some areas which may have affected treatment results in the 15 patients under study, namely, diagnosis, treatment since discharge, and recommendation on discharge and carrying out of the same.

From Table VI it can be seen that the majority of the patients had psychiatric treatment following discharge. The greatest number of patients, or six, have received regular treatment since discharge; three had regular treatment for a time and one had only a brief contact following discharge from hospital. Of the remaining five patients, three had medical treatment and two had no treatment. Of the nine patients making a satisfactory adjustment, six had psychiatric treatment following discharge, one had a brief contact, one had medical treatment, and one had no treatment. Of those patients who were not making a satisfactory adjustment, three had psychiatric treatment following discharge, two had medical treatment and

Table VI - Adjustment of 15 Patients Classified According to Treatment Since Discharge.

ADJUSTMENT	TREATMENT SINCE DISCHARGE					
	TOTAL	REGULAR TREATMENT SINCE DISCHARGE	REGULAR TREATMENT FOR A TIME	BRIEF CONTACT	MEDICAL TREATMENT	NO TREATMENT
TOTAL	15	6	3	1	3	2
SATISFACTORY ADJUSTMENT	9	4	2	1	1	1
UNSATISFACTORY ADJUSTMENT	6	2	1	-	2	1

one had no treatment. This would indicate that the greater number of those patients receiving follow-up therapy were making a satisfactory adjustment, whereas the greater number of those patients having medical treatment or no treatment since discharge were making an unsatisfactory adjustment.

In Table VII it can be seen that the greater number, or eight patients, carried out discharge recommendations, while seven did not follow suggestions. Of those eight patients who carried out recommendations, the majority, or six persons, were making a satisfactory adjustment, and two were making an unsatisfactory adjustment. Of the seven patients who did not follow recommendations at discharge, the majority, or four, were considered to be making an unsatisfactory adjustment, while three were making a satisfactory adjustment. This would indicate that the majority of those who carried out discharge

Table VII - Adjustment of 15 Patients Classified According To Recommendation At Discharge.

ADJUSTMENT	TOTAL	RECOMMENDATION AT DISCHARGE CARRIED OUT	RECOMMENDATION AT DISCHARGE NOT CARRIED OUT
TOTAL	15	8	7
SATISFACTORY ADJUSTMENT	9	6	3
UNSATISFACTORY ADJUSTMENT	6	2	4

plans were adjusting satisfactorily, whereas, of those who ignored discharge plans, the greater number were not adjusting satisfactorily.

The following cases[1] will serve to illustrate the four levels of adjustment.

NORMAL ADJUSTMENT[2] - CASE A

> Patient, aged 61 years, is a single man who had apparently managed adequately until six months prior to his first admission to the A. M. I. on July 10, 1948. At that time his problem consisted of depression with anxiety, together with considerable somatic symptomology in the form of tremor of hands and dragging pains in the corner of his eyes. He was eating poorly, had lost considerable weight, required sedation to sleep, and had lost interest in things. He responded rapidly to electro-convulsive therapy[3] and at discharge on August 6, 1948, his depression had entirely disappeared. The diagnosis was endogenous depression. Patient returned to work as a janitor and was symptom free until four months prior to readmission to the A. M. I. on September 1, 1949, when he presented complaints similar to those displayed on first admission. He again received E. C. T. and at discharge on October 7, 1949, he was doing well although with a mild hypomanic reaction. Diagnosis was again endogenous depression. Patient was to return for follow-up psychotherapy and monthly prophylactic E. C. T. He returned once to let the doctor know he was getting along and has not returned since.
>
> When he was visited four months after discharge, he had no complaints and reported he was in perfect condition. He was sleeping well, eating well and had gained 30 pounds in weight. The tremor of his hands was gone. Following discharge he had felt weak but his strength had gradually returned and for three weeks prior to follow-up interview he had felt in perfect shape. While he had

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[1] Much of the material in single space was copied verbatim from the psychiatric records.

[2] For definition of Supra p. 9.

[3] Hereafter referred to as E. C. T.

> not returned to work, he was ready for such but was waiting until spring for a seasonal type of work in which he had been employed most of his life. The patient is a single man and he has no family. He has been boarding with a family for 10 years and since discharge he has been helping to redecorate the home. He was carrying on his usual activities and he had no difficulty in mixing with people.

The diagnosis on both admissions was endogenous depression. Treatment with E. C. T. on both occasions alleviated the patient's symptoms, enabling him to make a satisfactory adjustment. The psychotic depression is considered by Dr. Moore as "a psychosis with an evident tendency to clear and relapse."[1] Dr. Hinsie states that the majority of these patients "recover from their symptoms, returning to their condition as it was before the onset of their illness, this with or without any specific treatment measures."[2] Since the psychotic depression is characterized by episodes of depression which usually clear up, it would be expected that the patient might make a satisfactory adjustment, especially since he had responded well to treatment during a previous depressive episode. However, there is no guarantee that the patient will not have a further recurrence. On discharge it was recommended that prophylactic E. C. T. on a monthly basis be carried out in an attempt to prevent further recurrence of a depression. The patient had

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1 Moore, T. V., "The Essential Psychoses and their Fundamental Syndromes", Studies in Psychology and Psychiatry from the Catholic University of Washington, Washington, D. C., Vol. 3, No. 3, (1933).

2 Hinsie, L. E., op cit., p. 10.

been feeling so well that he did not see the need for such and has not returned to the hospital.

At the time of follow-up, therefore, the patient had no complaints and was carrying on his usual activities without trouble.

NORMAL ADJUSTMENT[1] - CASE B

Patient, a 27 year old married woman, was admitted to hospital on September 6, 1949. At that time her primary difficulty consisted of depression and inadequacy which came on shortly after an attack of influenza in May. At that time she was nursing her baby which was born in January. She became progressively more exhausted and depressed, she could not keep up with her work, she began to worry about inadequacy and fatigue, and she started to feel confused. She had a good deal of difficulty in getting out of bed, she had trouble sleeping, and she became quite tense. On the advice of the family physician she took a vacation which did not help her condition and she was eventually admitted to the A. M. I.

Her family background was not very satisfactory. Her father was a domineering individual of whom she was afraid, although she was his favorite. Her mother was passive and friendly, but non-contributory. The patient was the fifth eldest of eight living siblings, all of whom were unstable. One sister was a homosexual and another had a nervous breakdown after her third child. Another sister was a nymphomaniac. The patient had sustained relationships with her friends and family by developing a patter of withdrawing from difficult scenes.

The patient was of superior intelligence. She completed high school and a course in dental nursing. Following this, she was employed as a dental nurse and she did a capable and efficient job until her marriage in 1945. She had one child born in January, 1949. The marital relationship was not satisfactory, and it was noted that her husband was an unstable individual with recurrent mild depression and anxiety.

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[1] For definition of supra p. 9.

While she was in hospital, the patient thought she was pregnant despite repeated negative A - Z tests. During the latter part of hospitalization there were rather marked ideas of reference. She received somnolent insulin and psychotherapy and later E. C. T. She responded well to treatment and at time of discharge she was relatively free of her depression and anxiety, but with very little insight. She still retained her ideas of reference. Diagnosis was paranoid development in an unstable individual who has shown considerable dependency and some early reactive depression. On discharge, follow-up psychotherapy was recommended with question of further E. C. T. The patient has been seen weekly in psychotherapy at the A. M. I. since discharge and it was felt that she was getting on much better.

When visited five months after discharge, the patient was feeling better than she had ever felt in her life and she complained only of a slight difficulty with sleep. She had felt much better on discharge from hospital but she had no understanding of why she was sick. She continued in psychotherapy after discharge to find out why she was sick and she had gradually gained insight and every day she understands more. She now realizes her whole family are sick, understands why they are, and is able to detach herself from them. She has developed an understanding of the incompatibility with her husband and the role this has played in her illness. While she has taken measures to change this relationship, she has some doubts of her ability to handle the situation. She realizes that she used to be a doormat but feels that she can now stand up for herself and she is no longer fearful of scenes. She has been able to carry on her household duties and care for the baby without difficulty. The patient has carried on her usual social activities with ease.

The diagnosis was paranoid development in an unstable individual who has shown considerable dependency and some early reactive depression. Treatment with somnolent insulin, psychotherapy, and E. C. T. alleviated her symptoms of depression and anxiety, but she had little insight into her illness on discharge and retained some ideas of reference.

Follow-up psychotherapy once a week was still continuing at the time of the writer's interview with her. This has enabled the patient to gain insight into her illness and to change her pattern of behaviour. With this understanding she has been able to free herself from her own family and to direct her energy toward a more mature marital relationship. Since her husband is a rather unstable person, her attempts in this direction may not be too successful. If she should meet with failure, it is possible that her newly gained strength might not carry her through the crisis.

At the time of follow-up, however, she was feeling better than at any previous time, and she was able to stand up for herself for the first time in her life. She was able to carry on her household duties without difficulty and to enjoy her normal social activities. While she felt better than before, she still had some symptoms which have reflected in disturbed sleep and some doubts about her ability to handle the marital maladjustment.

At the time of follow-up, therefore, the patient had some areas of disturbance which interfere with a maximum happiness and efficient performance.

POOR ADJUSTMENT[1] - CASE C

The patient, a 23 year old single girl, was admitted to hospital on August 31, 1949, following a sudden onset of depression and mutism two weeks prior to admission. While on the job as an elevator operator, the patient had uncontrollable crying spells and she had to be sent

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[1] For definition of supra p. 9.

to a sister's home. For three days she did not speak nor eat and she failed to recognize anyone. On the third night, these symptoms disappeared but she remained irritable and depressed. On admission she was tense, anxious, jittery, and confused. Diagnosis was hysterical reaction. She responded well to somnolent insulin and psychotherapy and she was discharged on October 24, 1949, her condition described as making a much better adjustment. On discharge it was recommended that the patient continue group therapy and study groups at the A. M. I.

At the time of follow-up, six months later, the patient was working as an elevator operator and she was helping to support her mother and brother. On discharge from hospital, the patient had put on weight and was feeling well. She returned to her job but soon she began losing considerable time due to tonsillitis and after one month she had to leave her job. One month later she was hospitalized for a tonsillectomy. Following convalescence she was unable to secure work and, with the concern about finances, she became jittery, tense and depressed. Three weeks before follow-up the patient secured a job as elevator operator and, while she is not satisfied with the job, she has felt better since she began working. She sleeps well as a rule but occasionally has nightmares and she awakens in a cold sweat. Her appetite is poor and she has lost weight since discharge from hospital. The patient cries some but she feels that she is not as upset by all her difficulties as she was before hospitalization. She returned to group therapy twice following discharge, but when she was unable to attend regularly because of her illness, she stopped, thinking that the doctors would not approve of the irregular attendance. She wanted to continue and she wondered if she would be allowed to start again. The patient has no close friends and her only contacts are with her own siblings. Extreme financial difficulties prohibit any interests or activities she would like to carry out and as a consequence she is spending most of her leisure time sleeping in one room which she shares with a sister.

The diagnosis on admission was hysterical reaction. Treatment with somnolent insulin and psychotherapy alleviated her symptoms and on discharge she was making a much better adjustment. The patient relapsed when illness, and hospital-

ization for tonsillectomy effected financial hardship through loss of employment and difficulty in securing another job. The return of symptoms and anxiety were not as severe as on admission and the patient was able to secure employment. The securing of a job helped her to feel some improvement, but she is dissatisfied with the job and she has symptoms, anxiety and poor social relations.

At the time of follow-up, therefore, the patient has emotional and social impairment reflected in symptoms, anxiety, and poor performance. However, she still has some ability to function.

NOT ADJUSTING - CASE D[1]

> The patient, a 22 year old single girl, was admitted to hospital on August 13, 1949. At that time she talked continuously in a nonsensical fashion and presented visual and auditory hallucinations and delusions. A year prior to admission to hospital she had shown a loss of interest in things, she did not want to go out or talk to people and she would just sit around the house. About a month prior to admission to hospital her behaviour changed completely. She would not work, she became careless of her person and she talked incessantly. Also her legs became swollen. The diagnosis was catonic schizophrenia. Patient received E. C. T. and coma insulin. At the time of discharge on October 28, 1949, she was reported to have good contact with her environment but her delusions remained intact, and she believed she was 13 difference people. While she had made a decided improvement, it was felt that she might have to be committed in the near future. Following discharge the patient was to receive follow-up care by a private psychiatrist.

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[1] For definition of supra p. 9.

At the time of the follow-up interview, five months later, the patient was living at home and she felt much better. She had many complaints of weakness, tension at the back of her head, and queer feelings over her right ear which made a sound like the hum of a record player. She had difficulty in talking as her throat filled up. She frequently forgot what she was going to say and she also complained of trouble in hearing. "This," she explained, "is because I'm thinking too deeply." On a few occasions she "imagines she hears her brothers talking to her" when she is alone in the house. She sleeps without difficulty but she has trouble waking up in the mornings. She sleeps 12 hours nightly and she occasionally has frightening dreams. Her appetite is fairly good.

At the time of the follow-up interview the patient was alone in the house and she answered the door dressed in a housecoat and sweater. After admitting the visitor, she disappeared, returning minutes later wearing a skirt and blouse over the housecoat and having her hair freshly combed. The clothes were spotted and mussed and the housecoat hung about 10 inches below the skirt. Her speech was slow and brief but not inappropriate. She smiled frequently in an immature manner and said she was glad to have a visitor because she needed someone to get her to talk. She kept looking toward the adjoining room as if somebody were there. This may have been evidence of hallucinations, or embarrassment in talking to a stranger. Patient had not carried out discharge plans but was thinking of getting around to it soon.

The patient lives at home with her father, two brothers, and the fiancee of one brother, all of whom work, while the patient stays alone all day. She finds it lonesome and she stated that a change cheered her up. Her only contacts are with the family. She visits occasionally with a sister-in-law who lives nearby. Once a week she enjoys a show. On such occasions she is accompanied by a brother. Recently she attended church alone, this being the first time since hospitalization. During the day she practices typing, draws, and occasionally prepares lunch. She doesn't do much housework as she feels too weak.

The diagnosis was catonic schizophrenia. Treatment with E. C. T. and coma insulin alleviated the acute excitement and

hallucinations. On discharge the patient had good contact with her environment but her delusions remained intact. When followed-up five months later, the patient reported some delusions and occasional hallucinations. However, they were not so severe as on admission to hospital, and she had considerable insight into her complaints and the need for help in keeping contact with reality. Dr. J. C. Coleman states that the prognosis for the catatonic schizophrenic reaction is more favorable than for some other types of schizophrenia because ". . . malignant reactions have not become established as yet and the individual, though panic-stricken, is still fighting desperately to save himself and resist personality disintegration."[1] The patient has been helped considerably, but she still has many psychotic symptoms and she is struggling to resist disintegration. She tries to handle her activities in a more constructive manner, but succeeds only in a limited way and she realizes that she needs more help.

At the time of follow-up, therefore, the patient indicated severe emotional and social impairment and the need for intensive treatment.

In summary, then, 15 patients were followed-up from four to seven months after discharge from hospital. It was found that 14 patients benefited by treatment and one case did not

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[1] Coleman, J. C., Abnormal Psychology and Modern Life, Chicago, (1950).

receive any benefit but was no worse than when he was admitted to hospital. In comparing the patients' adjustment to a normal adjustment, it was found that nine patients, or 60 per cent, were making a satisfactory adjustment, whereas six patients, or 40 per cent, were making an unsatisfactory adjustment.

In this sample group, it was found that the neurotic patients received greater benefit than did the psychotic patients. The one case of alcoholism did not receive any benefit. It was found that the majority of the patients had psychiatric follow-up therapy. Moreover, follow-up treatment appeared to increase the benefit received by the group of patients. The majority of the patients carried out discharge recommendations. The carrying out of discharge plans appeared to be a factor in the increased adjustment of the patients following discharge from hospital.

In this chapter the writer has discussed the patients' adjustment in terms of alleviation of symptoms. In this connection Dr. Burling states:

> Rehabilitation is the organization of effort to bring about functional restoration of the patient. It rests on the recognition that injury and disease are meaningful simply because they interfere with the integrated activity of human beings. Removal of symptoms, however, is meaningless busy work unless it is one step toward the patient's return to full human living.[1]

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[1] Burling, T., "The Vocational Rehabilitation of the Mentally Handicapped", American Journal of Orthopsychiatry, (January, 1950), Vol. XX, No. I.

As Dr. Burling has indicated, an evaluation of the patients' adjustment following treatment must take into consideration more than the alleviation of symptoms. It must consider the personal, social, and vocational adjustment of the patients.

It is the social adjustment of the patients that we will therefore be concerned with in the next chapters. Chater IV will discuss the patients' adjustment to family living, while Chapter V will consider the patients' adjustment with respect to friends, work and recreation.

CHAPTER FOUR

ADJUSTMENT OF PATIENTS TO FAMILY ENVIRONMENT

The Committee on psychiatric social work of the group for the Advancement of Psychiatry gives this statement of the function of the mental hospital: "Goal of treatment is seen as return to community living, with the fullest utilization of all medical resources for the personal, social and vocational rehabilitation of the patient."[1] In the previous chapter we have discussed the symptomatic adjustment of the patients under study and noted that the majority of the patients were making a satisfactory adjustment. Since the alleviation of symptoms is only a part of the total rehabilitation of the patient, the social adjustment must be considered in order to provide a more complete evaluation of the total adjustment of the patients.

In this chapter we shall consider the patients' home environment and how this has been effected by treatment. Dr. Hamilton states, "In any concept of therapy we must recognize how needs are gratified. Some needs must be gratified concretely, while other needs must be met through a process of education and reorganization of the functions of the personality; the latter are assumed to be the special area of psychotherapy."[2] While it is recognized that there is no substitute

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[1] "The Psychiatric Social Worker in the Psychiatric Hospital", prepared by Committee on Psychiatric Social Work, Group for the Advancement of Psychiatry, January, 1948, Report No. 2.

[2] Hamilton, G., "Psychotherapy in Child Guidance", N. Y., 1948.

for family relations, therapy can offer some help by enabling the patient, through change in attitudes, to make a better use of these relationships. Concrete help can also be given by relatives in providing healthier attitudes and understanding of the patient, which in turn leads to improved relationships. Although it is realized that improved family living may be brought about through therapy or through the family, it is not the purpose of this study to evaluate treatment. This study will only attempt to indicate effectiveness of treatment in terms of the patients' adjustment in family living as they are seen four to seven months following discharge from hospital.

The analysis will consider whether the patients' follow-up adjustment to family environment is better, the same, or worse than when the patient was admitted to hospital. These broad terms will be based on inferences of the writer as gained from observation of behaviour and what the patients said about their home environment.

The second plane of analysis will be made of the family environment at the time of follow-up in terms of whether the home environment is satisfactory or unsatisfactory. Satisfactory home environment will be defined as satisfying and happy home environment with a minimum of anxiety. If there are some areas of difficulty which interfere with the maximum

satisfying and happy home environment but these are not too great, the environment will still be considered satisfactory. Unsatisfactory home environment will be defined as severe difficulties in home environment, reflected in anxiety and impairment of the patient's social functioning.

When they were admitted to hospital, 13 of the 15 patients had been living with their families and two patients had been living apart from their families. Of the 13 patients who had been living with their families, eight patients were married and all of them had been living with their spouse and children. One patient was a widow and she had been living with a single adult son. The remaining four patients who had been living with their families were single. Three of the single patients had been living with parents and siblings, and one had been living with a married sibling. Of the two patients who had been living apart from their families, one was boarding and the other was rooming. On their discharge from the hospital, all of the patients but one returned to the same home. The one patient who changed his living quarters was a single patient. He left the home of his parents and went to live with a group of theatrical people who are living together.

On admission to hospital, 13 of the 15 patients indicated problems in family living. In the remaining two cases, the hospital records did not provide information concerning the home environment. With respect to the 13 patients who

expressed difficulties in family living on admission to hospital, seven were married persons, five were single, and one was a widow. A discussion of the type of problems in family living experienced by the group of patients will serve to illustrate the two planes of analysis. The discussion will be in terms of marital status of the patients.

A. Problems in Family Living Experienced by the Married Patients.

Of the seven married patients with problems in family living on admission to hospital, one patient expressed difficulty only in her sexual relations with her husband. She did not receive satisfaction from sexual intercourse. When she was followed-up, this patient indicated that she had felt neglected by her husband before hospitalization. Her husband had always been busy, was working hard, and was never able to relax. He worked night and day, even on Sundays and holidays. When he came home at night, he was so tired that he fell asleep immediately. The patient stated her feeling of neglect thus: "I used to feel he wasn't interested any more. We like a little attention." Her illness had worried her husband and, since she has been discharged from the hospital, he has spent more time at home. At time of follow-up this patient still expressed maladjustment in her sexual relations but she was receiving some support from her husband. The family living was better than at the time she was admitted to hospital and she was making a satisfactory adjustment in the home environment.

One patient expressed severe marital discord on admission to hospital. Her husband had been having extra-marital affairs and drinking excessively for years. At the time of follow-up there was still severe marital discord. Her husband was no longer displaying infidelity but he was very difficult to live with. He was always telling her she was crazy and ordering her to get out of the home. The patient claimed she wouldn't put up with her husband if she did not think so much of him. When the patient first learned of her husband's philandering, she retaliated with an extra-marital affair herself. Since then she has felt no good as a mother, a woman or a wife. She resents her children but cannot allow herself to show it. At the time of follow-up, therefore, the home environment was the same as when the patient was admitted to hospital. The patient was receiving no support from her husband and the home environment was unsatisfactory.

Two married patients expressed sexual maladjustment and problems centering around interfering parents when admitted to hospital. One of these patients was an extremely immature woman who, on admission to hospital, had been unable to accept or take part in adult sexual activities. She indicated conflict with her parents, resenting her dominating mother, and being strongly attached to her father. When followed-up, this patient indicated no problems in family living. She stated that her parents were very close to her and her family

and they had helped to pay her hospital bills. This patient had been hospitalized for medical treatment after discharge from the A. M. I. and felt all her trouble had been due to this rather than to emotional conflicts. She was antagonistic toward the A. M. I. and was denying any conflicts in family living. At time of follow-up, therefore, this patient was making a better adjustment to her home environment than when admitted to hospital. She was making a satisfactory adjustment to family living.

On her admission to hospital one patient had problems in family living with respect to sexual maladjustment, interfering in-laws, and conflicts arising through marriage into a higher social and economic level. When followed-up, this patient indicated that she had hated the manner of living necessitated by her marriage into a higher social level than that to which she had been accustomed. She was living in a three-storey mansion in Westmount and had always dreamed of a cosy little cottage. She stated that she had now accepted the situation and was trying to be a good administrator instead of wanting to do the homemaking herself. Her husband had been most understanding of her illness and he had been a great support to her. Following discharge from the hospital she was sensitive about her breakdown, but now she and her husband joke about it and he tells her he will call the boys up on the hill and they will come down with their butterfly

nets and catch her.

One patient had sexual maladjustment and difficult sibling relations when he was admitted to the hospital. This patient's illness coincided with his wife's return from the Verdun Protestant Hospital where she had been treated for a post partum psychosis. His wife had always been the dominant partner in the marriage. At time of follow-up this patient indicated that he never kept anything from his wife and there was no difficulty in their relationship. His wife was present during the interview and she sat quietly without saying anything until the latter part of the interview. There was no disagreement and each seemed to go out of the way to take any blame and to protect the other. Both felt that the wife's illness had been the cause of the patient's upset. Prior to the patient's hospitalization this family had lived in an area of the city where there was constant noise, day and night, from neighbours and trains. After his discharge from hospital, they secured a flat in another part of the city where it was quieter and more accessible to pleasant walks. This change had provided a relaxing atmosphere to which they attributed considerable benefit in family living. The patient was concerned about his brother's attitude toward him. He stated his concern thus: "Because I lead a quieter life doesn't mean my way of life is wrong." At time of follow-up this patient was receiving support from his wife and there was an improved

home environment, but he was still concerned over his brother's attitude toward his manner of living. The patient was, therefore, making a better adjustment in family living at time of follow-up than on admission to hospital, and this adjustment could be considered satisfactory.

One married patient had sexual maladjustment, interfering in-laws and parents, and problems in relation to siblings when she was admitted to hospital. She had never been able to become independent of her parents and siblings, all of whom were extremely unstable. Her marriage was not satisfactory because of her husband who was an unstable individual with recurrent depression and anxiety, and because of a dominating and interfering mother-in-law. In the past, this patient had sustained relationships by developing a pattern of withdrawing from difficult scenes. At time of follow-up this patient had gained insight into her illness. She realized that her whole family were neurotic and she had been able to detach herself from them. She placed the blame for her illness on the attitude of her husband and mother-in-law toward her, and she had considerable insight into the role she had played in the poor relationships. She felt she used to be a doormat but now she was able to stand up for herself and she was no longer fearful of scenes. She felt that the marriage lacked teamwork and that her husband did not share

responsibility for the home. She had recently discussed the need for co-operation with him and she had suggested a separation if he was not willing to try to improve their relationship. While she had some doubts of her handling of the marital relationship, it did not seem to cause her undue concern and she was feeling better than at any time in her life. At time of follow-up, therefore, this patient had been enabled, through treatment, to improve her relationships with parents, siblings, and her mother-in-law. Also, she was attempting to improve the marriage relationship. Her family living was better than on her admission to hospital and she was making a satisfactory adjustment at time of follow-up.

In one case the home environment was not known, neither when the patient was admitted to hospital nor at time of follow-up. This patient was an alcoholic.

The problems indicated by the married patients, therefore, included the sexual maladjustment of six persons and marital discord of one. In one case conflicts arose through marriage into a higher social level. Four patients indicated difficulties in family living because of interfering in-laws or parents. In two cases there were maladjusted sibling relationships which caused difficulties in family living.

B. <u>Problems in Family Living Experienced by the Single Patients</u>

Four single patients expressed incompatibility with their parents when admitted to hospital. One patient resented her

parents both of whom were unstable. Her father was an alcoholic and her mother was nervous and jittery. With considerable difficulty the patient had been able to leave home and had been rooming for a year prior to admission to hospital. When followed-up, the patient was still upset by her relationship with her family, feeling that they treated her differently and did not discuss things freely with her. She felt it necessary to visit her family weekly and she tried to be gay, but she always felt tired after the visits. She would rather not see any of her family. She was satisfied to be living alone. She had one friend whom she had met in hospital. This friend was living in the same house and they ate supper together. At time of follow-up this patient had been able to detach herself physically from her family but not emotionally and this gave her considerable anxiety. However, she was unable to form relationships excepting with one friend and she was withdrawing from social living. The support provided by the one friend enabled her to make a better adjustment than at the time of admission to the hospital, but her withdrawal from interpersonal relationships and dependence upon her family was an unsatisfactory adjustment.

One single patient had withdrawn from reality and she had become completely dependent upon her family at the time of admission to hospital. She was unable to form interpersonal relationships. When followed-up, this patient was

still unable to form relationships outside the home but she was making a better adjustment to the family. The family was providing support in not exerting pressures on her and in helping her to face reality. She was permitted to do housework whenever she felt able and to do almost as she pleased. However, the family encouraged her to face reality by taking her to movies, providing a typewriter, and visiting back and forth with her. At time of follow-up, therefore, this patient was making a better adjustment in family living than when she was admitted to hospital, but her adjustment was not satisfactory.

One single patient expressed incompatibility with his parents and sibling rivalry when admitted to hospital. After his discharge from the hospital, a friend suggested he go to live with a group of theatrical people. He did this because he realized that his relationship with his parents upset him and he might be better off away from home. He had realized this before his illness and he tried to make the break by going to work in another city. He had only felt worse and, when he became ill, he had had to return home. In the communal living, the patient helps about the house, looks after fires, gets wood, and helps the actors to prepare props and does other odd jobs. They all work together and the patient felt that this group had helped him considerably. While he has been able to make a better adjustment to family living,

he has considerable anxiety with respect to his dependency upon his family. While he has been helped by the communal living, he has difficulty in his relationships. He is therefore making an unsatisfactory adjustment to family living.

The home environment of one single patient was not indicated in the hospital record. At the time of follow-up it was found that he was boarding with a family and had been with them for ten years. He was able to come and go as he pleased without any questions being asked. If he felt like being with the family, he was accepted and, if he wanted to be alone, no demands were placed upon him. He sometimes played cards with the family, or took the dog out for a walk. Since discharge from hospital he had been helping the family to redecorate the home. At the time of follow-up, therefore, he was making a satisfactory adjustment to his living environment.

The problems indicated by the single patients, therefore, included incompatibility with parents of four persons, dependency and regression of one patient, and sibling rivalry with one patient. In one case the home environment was not known.

C. Problems in Family Living Experienced by the One Widow

The one widow expressed a grief reaction to her husband's death and concern regarding an immature, dependent son at the time of her admission to hospital. She had ambivalent feelings

toward her husband who, prior to his death, had made a practice of going out with other women. Her adult son worried her because he did not settle down and brought women into the home to sleep. The patient did not approve of this behaviour. At time of follow-up the patient expressed concern about her son's drinking. However, she was happy because he had recently become engaged and was to be married soon. She had been worried as to what would become of him if anything happened to her. She had always spoiled him and he was so dependent upon her that she was certain that he would become a tramp if anything happened to her. Now that he was to be married and would have somebody to look after him, the patient was greatly relieved. The son and his fiancee have invited her to live with them and this has pleased her very much. The son was very much attached to the patient and gave her what help he could. At the time of follow-up, therefore, this patient was making a better adjustment in the home and was making a satisfactory adjustment in family living.

D. Adjustment in Family Living of the Fifteen Patients

On their admission to hospital 13 patients indicated problems in family living and in two cases the home environment was not indicated in the hospital records. Of the 13 patients, 10 patients indicated a better adjustment to family living four to seven months after discharge, compared with their adjustment on admission to hospital. In the remaining

three cases, the home environment was found to be the same as when the patients were admitted to hospital. None of the patients was found to have made a worse adjustment in family living at the time of follow-up compared with his adjustment at the time of his admission to hospital.

These broad terms of comparison, previously stated as the writer's terms, indicate that ten patients received benefit in their home environment through hospitalization and treatment. Three patients did not receive any benefit but their family living was no worse than when they were admitted to hospital. In two cases the home environment prior to admission to hospital was not known.

This broad basis of comparison serves to indicate the direction of change. In order to indicate what this means to the patients in terms of their adjustment at the time of follow-up, a further analysis will consider whether the adjustment to family living is satisfactory or unsatisfactory.

From Table VIII it can be seen that the adjustment in family living of the 15 patients at the time of follow-up indicated that nine patients were making a satisfactory adjustment, five were making an unsatisfactory adjustment, and in one case, the adjustment was not known.

E. Factors Influencing the Two Planes of Analysis

While this study cannot evaluate treatment methods, the writer will discuss some aspects which may have effected

treatment results, namely, diagnosis, treatment since discharge, and recommendation on discharge and whether it was carried out.

From Table VIII it can be seen that of those patients who were making a satisfactory adjustment in family living, six were diagnosed as neuroses and three as psychoses. Those patients making an unsatisfactory adjustment in family living included two with diagnoses of neuroses, and three with diagnoses of psychoses. In one case the adjustment in family living was not known. In this case the diagnosis was alcoholism. This would indicate that six of the eight patients diagnosed as neurotic were making a satisfactory adjustment in their home environment. Only three of the six patients diagnosed as psychotic were making a satisfactory adjustment in family living. This would suggest that the neurotic patients were helped to make a better adjustment in family living than were the psychotic patients.

Table VIII - Adjustment in Family Living of 15 Patients Classified According to Diagnosis.

Adjustment in Family Living	Total	DIAGNOSIS		
		NEUROSES	PSYCHOSES	ALCOHOLISM
TOTAL	15	8	6	1
SATISFACTORY	9	6	3	-
UNSATISFACTORY	5	2	3	-
NOT KNOWN	1	-	-	1

From Table IX it can be seen that four of the nine patients who were making a satisfactory adjustment in their home environment had regular treatment following their discharge from hospital, two had regular treatment for a time, and one had a brief contact. One patient had medical treatment and one had no treatment. Of the five patients who had unsatisfactory family relationships, two had received regular treatment since their discharge from hospital, two had medical treatment and one had no treatment. The one case in which family relationships were not known had regular treatment for a time. This would suggest that six of the nine patients receiving follow-up therapy were making a satisfactory adjustment in their family living, whereas three of the

Table IX - Adjustment in Family Living of 15 Patients Classified According to Treatment Since Discharge

ADJUSTMENT IN FAMILY LIVING	TOTAL	TREATMENT SINCE DISCHARGE				
		REGULAR TREATMENT SINCE DISCHARGE	REGULAR TREATMENT FOR A TIME	BRIEF CONTACT	MEDICAL TREATMENT	NO TREATMENT
TOTAL	15	6	3	1	3	2
SATISFACTORY	9	4	2	1	1	1
UNSATISFACTORY	5	2	-	-	2	1
NOT KNOWN	1	-	1	-	-	-

five patients having medical treatment or no treatment since discharge from hospital, were making an unsatisfactory adjustment. This would further suggest that follow-up treatment was an important factor in effecting improved family living.

From Table X it can be seen that eight patients carried out discharge recommendations. Of those eight patients who carried out recommendations, six persons had a satisfactory home environment and two persons had an unsatisfactory home environment. Of the seven patients who did not carry out discharge recommendations, three persons had a satisfactory home environment, three had an unsatisfactory home environment and in one case there was no information about family living. This would indicate that the six of the eight patients who carried out discharge plans had a satisfactory family environment, whereas of those patients who ignored discharge

Table X - Adjustment in Family Living of 15 Patients Classified According to Recommendation at Discharge

ADJUSTMENT	TOTAL	RECOMMENDATION AT DISCHARGE CARRIED OUT	RECOMMENDATION AT DISCHARGE NOT CARRIED OUT
TOTAL	15	8	7
SATISFACTORY RELATIONSHIPS	9	6	3
UNSATISFACTORY RELATIONSHIPS	5	2	3
NOT KNOWN	1	-	1

plans, three out of seven patients had satisfactory family living. This would suggest that the carrying out of discharge plans could be an important factor in effecting improved family living.

In summary, 13 of the 15 patients had been living with their families on admission to hospital, and two patients had been living apart from their families. All of the patients but one returned to the same home on discharge from hospital. On their admission to hospital, 13 of the 15 patients indicated problems in family living. In two cases the home environment was not known. Of the 13 patients with difficulties in family living, seven were married persons, five were single, and one was a widow.

The problems indicated by the married patients included sexual maladjustment, conflicts arising from marriage into a higher social level, interfering in-laws or parents, and conflicts in sibling relationships. The single patients indicated problems centering around incompatibility with parents, dependency and regression, and sibling rivalry. The one widow indicated conflicts in the home environment due to an immature and dependent son.

Of the 13 patients with difficulties in family living at the time of their admission to hospital, ten patients were making a better adjustment four to seven months after discharge, compared with their adjustment on admission to hospital. The

remaining three cases were found to be the same as they were on admission to hospital and none was worse. At time of follow-up nine patients were making a satisfactory adjustment to family living, five were making an unsatisfactory adjustment, and in one case the adjustment was not known.

It was seen that six of the eight patients diagnosed as neurotic were making a satisfactory adjustment to their home environment, while only three of the six patients diagnosed as psychotic were making a satisfactory adjustment in family living. This would suggest that the neurotic patients were helped to make a better adjustment in family living than were the psychotic patients.

With respect to the treatment following discharge, it was found that six of the nine patients receiving follow-up therapy were making a satisfactory adjustment in their family living, whereas three of the five patients having medical treatment or no treatment since discharge from hospital were making an unsatisfactory adjustment.

Six of the eight patients who carried out discharge plans had a satisfactory home environment, whereas of those patients who ignored discharge plans, three of seven patients had satisfactory family living.

In this chapter we have discussed the patients' adjustment with respect to family living. In order to provide a

more complete evaluation of the rehabilitation of the patients, we must consider their adjustment to their environment outside the home. Therefore, in the following chapter the writer will discuss the patients' adjustment with respect to friends, work and recreation.

CHAPTER FIVE

ADJUSTMENT OF THE PATIENTS WITH RESPECT TO FRIENDS, WORK, AND RECREATION

In the previous chapter the writer has discussed the patients' adjustment with respect to the family. In this chapter we will consider further aspects of the social adjustment of the patients with respect to friends, work, and leisure time activities. Since the hospital records did not provide sufficient information concerning the social adjustment of the patients, no attempt will be made in this study to compare the social adjustment of the patients at time of follow-up with the adjustment on the patients' admission to the hospital. The writer will only attempt to indicate the patients' social adjustment at time of follow-up relative to a "normal" adjustment, and whether it is satisfactory or unsatisfactory.

Since the individual's interactions with people outside the family are of vital significance to mental health, we shall be interested in knowing something about the patients' ability to form friendships. In this respect Dr. Cameron states, ". . . the individual's normal tendency is to reach out, to relate himself to others, to communicate, and that those who cannot do so in the appropriate setting are damaged personalities."[1]

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[1] Cameron, D. E., "General Psychotherapy", N. Y., 1950.

In this study we will consider those patients to be making a satisfactory adjustment in their interpersonal relationships if they are able to relate to people in an appropriate manner and have happy and satisfying friendships. Those patients who are unable to relate to people in an appropriate manner, and/or, do not have happy and satisfying friendships, will be considered to be making an unsatisfactory adjustment in their interpersonal relationships. Another psychiatrist, Dr. Coleman, states that,

> ". . . in order to achieve an effective adjustment to the surrounding world, an individual must learn to get along successfully with other people. Of great importance to all of us is a feeling of competence in dealing with people, of having good friends, and of 'belonging' to a group. From a more materialistic point of view, 'success', as measured by occupational advancement and the accumulation of material possessions, is heavily dependent upon one's social skills."[1]

As Dr. Coleman has stated, personal life is made significant and enriched by the quality of human relations one can sustain. The importance of interpersonal relationships is seen in all phases of everyday living whether it is in connection with family, friends, work, or play. Satisfying and efficient functioning in all these spheres is necessary for mental health.

Since most of our waking life is spent at work the occupational adjustment is an important factor in mental health.

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[1] Coleman, J. C., "Abnormal Psychology and Modern Life", Chicago, 1950.

Dr. Coleman emphasizes the importance of the work situation thus: "Freedom from worry, a sense of self-respect and accomplishment, hope for the future - all of these underlie happy family life and are fostered by healthy occupational adjustment."[1]

In this study we shall consider those patients to be making a satisfactory adjustment to their work who have a job in which they are performing efficiently and happily, or with a minimum of anxiety or tension. Those patients who do not have a job will be considered to be performing efficiently if their lack of employment is not due to social or emotional impairment. Those patients who are unable to work due to social and emotional impairment, or who are working with extreme anxiety or performing inefficiently, will be considered to be making an unsatisfactory adjustment.

In recent years there has been a general trend toward shorter working hours. This has provided the individual with more leisure time. Since every individual requires a balanced life of work and play, the use made of leisure time is important in providing an acceptable outlet for emotional drives. In this study we shall consider those patients to be making a satisfactory recreational adjustment who have satisfying interests and activities, some of which involve group

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[1] Ibid p. 67

participation. Those patients who have a minimum of interests and activities, none of which involves group participation, will be considered to be making an unsatisfactory adjustment.

A. Adjustment to Friends

When the patients were visited four to seven months after discharge from the hospital, five of the 15 patients indicated no problems in their interpersonal relationships and ten patients expressed difficulties in their relationships with friends.

Of the five patients who gave no indication of difficulty in their interpersonal relationships, two individuals stated that they had many friends and had no trouble mixing with people. Another patient indicated that she liked to go out with her friends now and she enjoyed it. One patient said that she had many friends whom she saw frequently. A single, older man stated that he sees some of the boys and chats.

1. Problems in Interpersonal Relationships.

In four cases difficulty in relating to people was indicated. All of these were single persons. In one case the patient had never been able to relate to people. His friends

had never seemed to understand him and he had been hurt by their attitude. He had needed their understanding and he had wanted encouragement from them. Since his discharge from hospital, he had been living with a group of theatrical people. He had been able to form a closer relationship with two male members of this group than he had ever made with people before. He felt that these friends were definitely interested in him and that they wanted to help him. One of these friends had asked the patient to go to Asia with him. It was suggested that they take a jeep and spend a year touring the continent. The patient was quite excited about this plan, and he felt that interesting himself in new places and in many people would be good for him.

In two cases the patients felt that their friends had not shown the same interest in them since their hospitalization. One patient had moved to another section of the city after his discharge from the hospital. He and his family had been in their new home for four months and none of their friends had so much as called them on the telephone, let alone come to visit them. The patient's wife sees their friends at church as she returns to their old church. She talks with them but they seem disinterested. The patient likes to attend the church in their new district because the people there do not know of his past illness. When he went to the old church where he knew most of the people, they asked about

his health, if he was working, etc, and seemed surprised that he was working. At the new church he felt accepted as an average person. He and his wife have talked about this matter considerably but they could not decide whether the strained relationship with former friends was because their own sensitivity prevented them from acting natural or whether their friends were reacting to the stigma of psychiatric treatment. Both agreed that they had not taken any initiative with their friends and they felt that perhaps they should. This loss of friendship has hurt them considerably as their friendships meant a great deal to them, especially since they never had a close relationship with their relatives.

A tension in their interpersonal relationships was indicated by two patients. In one of these cases the patient stated that he did not go out much now. He and his wife usually had a game of bridge with friends on Saturday night. While he did not find it a strain to mix with people, he felt it must really and unconsciously be difficult for him as he was exhausted the following day.

In two cases the patients stated that they mixed more with friends than usual in order to escape from their anxiety. One patient explained, "We keep going so as not to think too much about ourselves."

The problems in adjustment to friends, therefore, included difficulty in relating to people in four cases and a change in the attitude of their friends toward them since hospitalization in two cases. A tension in their relationships with friends was indicated in two cases and in two cases the patients socialized more in an attempt to escape from their anxiety.

2. Follow-Up Adjustment to Friends.

When they were visited four to seven months after their discharge from hospital, eight patients were making a satisfactory adjustment in their interpersonal relationships with friends, and seven patients were making an unsatisfactory adjustment. This would indicate that eight out of fifteen patients were making a satisfactory adjustment to their friends.

Of those patients making a satisfactory adjustment to their friends, one person explained that she had many friends and had no trouble mixing with people. She had always felt unwanted by her family and felt that she was different from the others in her family. Because of this, she had formed many friendships. She had a group of friends in their neighbourhood and they visited together a great deal. Also, she and her husband had many friends whom they visited and entertained frequently.

Of those patients making an unsatisfactory adjustment to friends, one patient stated, "I'm not the type to get along with people. I'm satisfied to live to myself as long as I can work and not feel tired." This person tries to go out with friends about once a week but she finds that it gives her considerable anxiety. However, she has one friend whom she met in hospital and later she obtained a room for her in the same rooming house at which she herself lodged. They eat suppers together and, as the patient explained, "We're company enough for each other." This patient was unable to relate to people without considerable anxiety and could be considered to be making an unsatisfactory adjustment to friends.

3. Some Aspects Which May Have Effected Treatment Results.

While this study cannot evaluate treatment methods, the writer will discuss some aspects which may have some effect on treatment results, namely, diagnosis, treatment since discharge, and recommendation on discharge and whether it was carried out.

From Table XI it can be seen that, of the eight patients making a satisfactory adjustment to friends, six were diagnosed as neuroses and two as psychoses. Those patients making an unsatisfactory adjustment included two with diagnoses of neuroses, four of psychoses, and one with a diagnosis of

alcoholism. In other words, six of the eight patients diagnosed as neuroses were making a satisfactory adjustment to friends at the time of follow-up, whereas only two of the six patients diagnosed as psychoses were making a satisfactory adjustment to friends. The one case of alcoholism was not making a satisfactory adjustment to friends.

Table XI - Adjustment to Friends of 15 Patients Classified According to Diagnosis at Discharge.

ADJUSTMENT TO FRIENDS		DIAGNOSIS AT DISCHARGE		
	TOTAL	NEUROSES	PSYCHOSES	ALCOHOLISM
TOTAL	15	8	6	1
SATISFACTORY	8	6	2	-
UNSATISFACTORY	7	2	4	1

It can be seen in Table XII that, of the eight patients making a satisfactory adjustment to friends, five persons had psychiatric treatment following discharge from hospital, one had a brief contact, one had medical treatment, and one had no treatment. Of the seven patients making an unsatisfactory adjustment to friends, four persons had psychiatric treatment following discharge from hospital, two had medical treatment, and one had no treatment. This would suggest that five of the nine patients receiving follow-up therapy were making a satisfactory adjustment to their friends, whereas only two of the five patients having medical treatment or no treatment

since discharge from hospital were making a satisfactory adjustment to friends.

Table XII - Adjustment to Friends of 15 Patients Classified According to Treatment Since Discharge.

ADJUSTMENT TO FRIENDS	TREATMENT SINCE DISCHARGE					
	TOTAL	REGULAR TREATMENT SINCE DISCHARGE	REGULAR TREATMENT FOR A TIME	BRIEF CON-TACT	MEDICAL TREAT-MENT	NO TREAT-MENT
TOTAL	15	6	3	1	3	2
SATIS-FACTORY	8	4	1	1	1	1
UNSATIS-FACTORY	7	2	2	-	2	1

From Table XIII it can be seen that, of the eight patients who had carried out discharge recommendations, five persons were making a satisfactory adjustment to friends and three were making an unsatisfactory adjustment. Of the seven patients who did not follow recommendations at discharge, three individuals were considered to be making a satisfactory adjustment to friends, while four persons were making an unsatisfactory adjustment. This would suggest that five of the eight patients who carried out discharge plans were adjusting satisfactorily to friends, whereas only three of the seven patients who ignored discharge plans were making a satisfactory adjustment to friends.

Table XIII - Adjustment to Friends of 15 Patients Classified According to Recommendation at Discharge.

ADJUSTMENT TO FRIENDS	RECOMMENDATION AT DISCHARGE		
	TOTAL	RECOMMENDATION AT DISCHARGE CARRIED OUT	RECOMMENDATION AT DISCHARGE NOT CARRIED OUT
TOTAL	15	8	7
SATISFACTORY	8	5	3
UNSATISFACTORY	7	3	4

B. Adjustment to Work

When the patients were interviewed four to seven months following discharge from the hospital, five of the 15 patients gave no indication of difficulty in their adjustment to their work, and ten persons expressed difficulties in this area of their social adjustment.

Of the five patients who gave no indication of difficulty in their work situation, four were housewives and one was gainfully employed outside the home. The four housewives stated that they were able to carry out their household duties without difficulty. In one of these cases, the patient's responsibilities in the home had been lessened through securing a capable housekeeper. The remaining three housewives were able to cope with the same responsibilities they had prior to hospitalization.

The one patient, employed outside the home, who expressed no problems in connection with his work, had returned to the same job. When he returned to work following discharge from the hospital, his employer gave him a different type of work which did not have as many pressures of phone calls and other interruptions as his old job. He was able to do his new work without difficulty. The patient had not requested the change and he felt that the firm had been very understanding and helpful.

1. Problems in Work Situation.

The problems indicated by the patients who were employed outside the home included one patient who had difficulty in finding work. This patient, a man over 60 years, felt weak for a time following discharge from the hospital. For three weeks prior to the follow-up interview, however, he considered himself to have been in perfect shape and ready for work. During this time he had been unable to find employment. However, he expected to be able to secure a seasonal type of work, in which he had been employed most of his life, in the near future.

In two cases the patients felt unable to return to work. Neither of these patients were working at the time of follow-up and they had not worked since their discharge from hospital. One of these patients had been a clerk in a department store prior to her illness. Since her discharge from

hospital she had not even thought about returning to work. At times she did some housework but very little work tired her. She used to enjoy cooking and recently she had considered baking a cake, but, after reading the recipe, she had been unable to do anything further.

In three cases the patients were working at the time of the follow-up interview but the work was unsatisfactory. One of these patients was an alcoholic. His job as a chemical engineer involved a great deal of entertaining. He did not find this satisfactory because he found that it increased his temptation to drink. Another of these patients was a script writer for the radio. This patient enjoyed creative work but her job did not hold her interest because it was not original script writing.

One patient experienced difficulty in his work because he was conscientious and he had to do everything perfectly. This patient worked as a clerk for a drug manufacturing company. One of his responsibilities had been checking drug directions. The patient took this work very seriously and he felt keenly that there must be no error. On his return to work following discharge from the hospital he had been relieved of this responsibility. Since he had been relieved of the one job that worried him, he had enjoyed his work. However, he felt that his need to do everything perfectly prevented him from working in a relaxed and comfortable manner.

Another patient expressed a lack of confidence in herself in connection with her work. She had worked steadily since discharge from hospital and she felt that she did her work efficiently and without too much strain. However, she did not have as much confidence in herself as she had prior to her illness. She was not greatly concerned about this lack of confidence as she felt that it would return.

The problems expressed by the eight persons employed outside the home therefore, included inability to secure employment in one case, and inability to work in two cases. Three patients found the nature of their work unsatisfactory. In one case the patient experienced tension in his work because of his obsessiveness. One patient expressed some difficulty in her work because she lacked the confidence in herself that she had prior to her illness.

Two housewives expressed difficulty in their work at the time of the follow-up interview. One of these patients had been unable to do her housework since discharge from the hospital. She felt physically able to do the work but she lacked the ambition and the interest to do the work. Because she needed the money and because she was not able to do her own work, the patient decided to work outside the home. She nursed a woman for several weeks. At the time of the follow-up interview, however, she had no employment and she was still unable to do her own housework.

The other housewife, who expressed some difficulty in her work, had trouble because of her obsessiveness about her housework. She has always had to have everything planned and done properly. She used to clean the entire house every day and she was not satisfied to mop the floors. Each day she cleaned all the floors on her hands and knees so that she could clean all the corners properly. She used to try to tell herself that it was foolish but she was never satisfied until the work was done in this manner. Since her discharge from the hospital she has been cleaning the house only twice a week. At times she found it hard not to do her work in the manner in which she had always done it. This caused some tension because it was an effort for her to change her pattern of working.

The problems of the housewives, therefore, included lack of interest and ambition in her work in one case and obsessiveness in her housework in the other case.

2. Follow-Up Adjustment to Work.

When they were visited four to seven months following their discharge from hospital, eight patients were making a satisfactory adjustment to their work, and seven patients were making an unsatisfactory adjustment. In other words, eight out of the 15 patients were making a satisfactory adjustment to their work.

Of those patients making a satisfactory adjustment to their work, one housewife stated that she was able to do her housework without trouble and she enjoyed doing it. Another patient, who was adjusting satisfactorily in his work, had been placed in a different type of work following discharge from the hospital. He liked his new job which did not have the pressure of phone calls and the interruptions of his old job. At the time of the follow-up interview, therefore, these patients were considered to be making a satisfactory adjustment to their work.

Of those patients making an unsatisfactory adjustment to their work, one person, a medical doctor, stated that he had been unable to return to the practice of medicine since his discharge from hospital. He had no interest in returning to work. When practicing medicine he had always felt his patients' complaints and this was very hard on him. He had not decided whether he would return to his profession or make a change. He would make that decision in time. At the time of the follow-up interview he was not working and was therefore making an unsatisfactory adjustment to his work.

3. Some Aspects Which May Have Effected Treatment Results

While no attempt can be made in this study to evaluate treatment results, this study will discuss some aspects which may have some effect on treatment results, namely, diagnosis, treatment since discharge, and recommendation on discharge

and whether it was carried out.

From Table XIV it can be seen that of the eight patients making a satisfactory adjustment to their work, six were diagnosed as neuroses and two as psychoses. Those patients making an unsatisfactory adjustment included two with diagnosis of neurosis, four of psychosis, and one of alcoholism. In other words, six of the eight patients diagnosed as neuroses were making a satisfactory adjustment to their work at the time of follow-up, whereas only two of the six patients diagnosed as psychoses were making a satisfactory adjustment to their work. The one case of alcoholism was making an unsatisfactory adjustment to his work.

Table XIV - Adjustment to Work of 15 Patients Classified According to Diagnosis.

ADJUSTMENT TO WORK	PSYCHIATRIC DIAGNOSIS			
	TOTAL	NEUROSES	PSYCHOSES	ALCOHOLIC
TOTAL	15	8	6	1
SATISFACTORY	8	6	2	-
UNSATISFACTORY	7	2	4	1

From Table XV it is noted that of the eight patients making a satisfactory adjustment to their work, six patients had psychiatric treatment following discharge, one had medical treatment, and one had no treatment. Of the seven patients making an unsatisfactory adjustment to their work, three had

psychiatric treatment following discharge, one had a brief contact, two had medical treatment and one had no treatment. This would indicate that the greater number of the patients receiving follow-up therapy were making a satisfactory adjustment to their work, whereas the greater number of those patients having medical treatment or no treatment since discharge from hospital were making an unsatisfactory adjustment to their work.

Table XV - Adjustment to Work of 15 Patients Classified According to Treatment Since Discharge.

ADJUSTMENT TO WORK	TREATMENT SINCE DISCHARGE					
	TOTAL	REGULAR TREATMENT SINCE DISCHARGE	REGULAR TREATMENT FOR A TIME	BRIEF CONTACT	MEDICAL TREATMENT	NO TREATMENT
TOTAL	15	6	3	1	3	2
SATISFACTORY	8	4	2	-	1	1
UNSATISFACTORY	7	2	1	1	2	1

From Table XVI it can be seen that of the eight patients who carried out discharge recommendations, the majority, or six patients, were making a satisfactory adjustment to their work and two patients were making an unsatisfactory adjustment. Of the seven patients who did not follow recommendations at discharge, the majority, or five patients, were considered to be making an unsatisfactory adjustment to their work, while two patients were making a satisfactory adjustment. This

would indicate that the majority of the patients who carried out discharge plans were making a satisfactory adjustment in their work, whereas of those patients who failed to carry out discharge plans, the majority were not adjusting satisfactorily in their work.

Table XVI - Adjustment to Work of 15 Patients Classified According to Responses to Recommendation at Discharge

ADJUSTMENT TO WORK	RECOMMENDATION AT DISCHARGE		
	TOTAL	RECOMMENDATION AT DISCHARGE CARRIED OUT	RECOMMENDATION AT DISCHARGE NOT CARRIED OUT
TOTAL	15	8	7
SATISFACTORY	8	6	2
UNSATISFACTORY	7	2	5

C. Adjustment to Recreation

When they were visited four to seven months after discharge from the hospital, eight of the 15 patients indicated no problems in their leisure time activities, and five patients expressed difficulties in their recreational activities. In two cases the leisure time activities of the patients were not known.

Of the eight patients who gave no indication of difficulty in their recreational activities, one person stated that woodwork was his hobby and he enjoyed it very much. He felt that everyone should have a hobby, something entirely different

from his work. He had been interested in this work for the past three years. A friend had a lathe and the patient worked at this friend's home one night weekly and on Saturday afternoons. The patient had done some leather work while he was in hospital and he felt that it would be a good hobby if space and equipment for woodwork was not available. In addition to this hobby the patient enjoyed a weekly game of bridge with friends. He also enjoyed the radio and he spent considerable time reading. In fact he seldom sat down without reading material. The patient appeared to be quite contented with his leisure time activities.

1. Problems in Recreational Activities.

Two persons expressed dissatisfaction in their leisure time activities because of insufficient income. One of these patients was working as an elevator operator and a portion of her small earnings were spent in contributing to the support of her mother and a brother. Because of this financial burden she had barely sufficient money on which to exist. Consequently her leisure time was spent in reading and in visiting her relatives. At one time she had entered into many activities of the church. When she was interviewed, the patient felt unable to join in the church groups because she could not contribute financially to their activities. She enjoyed the radio and music, but, at the time of follow-up,

her radio was broken and she could not afford to have it repaired. The patient also liked all types of needle work but she was unable to do any fancy work because of her inability to purchase the materials. At the time of follow-up, therefore, she was dissatisfied with her leisure time activities.

Two patients had difficulty in their recreational activities because of their regression and their inability to relate to people. One of these patients was unable to work and she stayed alone in the home all day. She practiced typing and she spent considerable time drawing. She found it lonesome but she was unable to form the intrapersonal relationships which would broaden the scope of her leisure time activities. Once a week she went to a movie with a brother. In speaking of this outing the patient stated, "A change cheers me up." She desired further recreation than she had at the time of the follow-up interview but she seemed unable to do anything constructive about it.

In one case the patient spoke of her problem in recreational activity as due to a change in her friends' attitude toward her following her discharge from the hospital. Because her friends had not shown any interest in her since her hospitalization, her activities had been confined to solitary interests. She went to shows frequently and she attended

church regularly. However, these activities did not satisfy her as she missed the group activities in which she had previously participated with her friends.

The problems in leisure time activities, therefore, included insufficient income in two cases and regression and inability to relate to people in two cases. One person was limited in her recreational activities because of a change in her friends' attitude toward her.

2. Follow-Up Adjustment to Recreation.

When they were visited four to seven months after discharge from the hospital, eight patients were making a satisfactory adjustment in their recreational activities and five patients were making an unsatisfactory adjustment. In two cases the recreational adjustment was not known.

Of those patients making a satisfactory adjustment in their leisure time activities, one patient had become active in a couple of organizations which were interested in charitable work. She had entered into this type of activity prior to her hospitalization, but, at that time, she was indifferent and she lacked interest in the work. Now, she had become interested in their work, and she was quite active in it. Recently she had a large tea in connection with this work. During the winter she had been skiing on several occasions. During the Christmas season she and her husband went on a

cruise to the West Indies and she enjoyed the voyage. The patient had always been afraid to drive a car because of her fear of killing someone. At the time of the follow-up interview she was driving a great deal, without fear, and she enjoyed it. As a child the patient had studied the piano but she had never made any use of this knowledge. Recently she began taking piano lessons. She received a great deal of enjoyment from this and she stated that it gave her satisfaction because she gained a feeling of achievement. She felt she was making progress in her piano accomplishment. At the time of follow-up, therefore, this patient had satisfying interests and activities, some of which involved group participation and she was considered to be making a satisfactory recreational adjustment.

Of those patients who were not adjusting satisfactorily in their leisure time activities, one person had few diversions at the time of follow-up. He enjoyed woodwork and he spent considerable time making repairs about the home. Aside from this activity he had no recreation aside from walks. He had always enjoyed swimming, boating and outside activities with his friends but he was not able to participate in these activities because of financial limitations. There had been considerable illness in the family in the past year and a half and the debts, brought about because of this, limited

the amount they could spend on recreation. At the time of follow-up, therefore, this patient had a minimum of interests and activities, none of which involved group participation and he was considered to be making an unsatisfactory recreational adjustment.

3. Some Factors Which May Have Effected Treatment Results

The writer will discuss some aspects which may have some effect on treatment results, namely, diagnosis, treatment since discharge, and recommendation on discharge and whether it was carried out.

From Table XVII it can be seen that of the eight patients making a satisfactory recreational adjustment, five were diagnosed as neuroses and three as psychoses. The patients making an unsatisfactory recreational adjustment included two with diagnosis of neurosis and three of psychosis. The two patients

Table XVII - Adjustment to Recreation of 15 Patients Classified According to Diagnosis at Discharge.

ADJUSTMENT TO RECREATION	DIAGNOSIS AT DISCHARGE			
	TOTAL	NEUROSES	PSYCHOSES	ALCOHOLIC
TOTAL	15	8	6	1
SATISFACTORY	8	5	3	-
UNSATISFACTORY	5	2	3	-
NOT KNOWN	2	1	-	1

in which the recreational adjustment was not known included one patient with a diagnosis of neurosis and one of alcoholism. In other words, five of the eight patients diagnosed as neuroses were making a satisfactory recreational adjustment at the time of follow-up; whereas, only three of the six patients diagnosed as psychoses were making a satisfactory recreational adjustment.

From Table XVIII it is noted that of the eight patients making a satisfactory recreational adjustment, six patients had psychiatric treatment following discharge from hospital, one had a brief contact, and one had no treatment. Of the five patients with an unsatisfactory recreational adjustment, two patients had psychiatric treatment following discharge

Table XVIII - Adjustment to Recreation of 15 Patients Classified According to Treatment Since Discharge.

ADJUSTMENT TO RECREATION	TREATMENT SINCE DISCHARGE					
	TOTAL	REGULAR TREATMENT SINCE DISCHARGE	REGULAR TREATMENT FOR A TIME	BRIEF CONTACT	MEDICAL TREATMENT	NO TREATMENT
TOTAL	15	6	3	1	3	2
SATISFACTORY	8	5	1	1	-	1
UNSATISFACTORY	5	1	1	-	2	1
NOT KNOWN	2	-	1	-	1	-

from hospital, two had medical treatment, and one had no treatment. In the two cases, in which the recreational adjustment was not known, one patient had psychiatric treatment and one had medical treatment. This would indicate that the greater number of the patients receiving follow-up therapy were making a satisfactory recreational adjustment, whereas the greater number of those patients having medical treatment or no treatment since discharge were making an unsatisfactory recreational adjustment.

From Table XIX it can be seen that of the eight patients who carried out discharge recommendations, six persons were making a satisfactory recreational adjustment and two were making an unsatisfactory adjustment. Of the seven patients who did not follow discharge recommendations, three persons were considered to be making an unsatisfactory recreational

Table XIX - Adjustment to Recreation of 15 Patients Classified According to Response to Recommendation at Discharge

ADJUSTMENT TO RECREATION	RECOMMENDATION AT DISCHARGE		
	TOTAL	RECOMMENDATION AT DISCHARGE CARRIED OUT	RECOMMENDATION AT DISCHARGE NOT CARRIED OUT
TOTAL	15	8	7
SATISFACTORY	8	6	2
UNSATISFACTORY	5	2	3
NOT KNOWN	2	-	2

adjustment, while two were making a satisfactory adjustment. The two patients, in which the recreational adjustment was not known, had failed to carry out discharge plans. This would indicate that the majority of those patients who carried out discharge plans were adjusting satisfactorily in their recreational activities, whereas the greater number of those patients who ignored discharge plans were not adjusting satisfactorily.

In summary, the follow-up adjustment of the 15 patients was considered with respect to friends, work and recreation. It was found that eight out of the 15 patients were making a satisfactory adjustment in all three areas of their social living.

The problems indicated by the patients in their adjustment to friends included difficulty in relating to people, changes in attitude of their friends, tension in relationships, and socializing in order to escape from their anxiety. The problems in work adjustment included inability to secure employment, dissatisfaction with the type of job, tension due to obsessiveness, lack of confidence, and lack of interest and ambition in work. The problems in the recreational adjustment were found to be insufficient income, regression and inability to relate to people, and changes in attitude of friends.

In this sample group it was shown that the neurotic

patients received greater benefit in all areas of their social adjustment than did the psychotic patients. The one case of alcoholism did not receive any benefit in his adjustment to friends nor work. His recreational adjustment was not known. Moreover, it was found that follow-up therapy and the carrying out of discharge recommendations appeared to increase the benefit received by this group of patients in all areas of their social adjustment.

CHAPTER SIX

ANALYSIS OF THE LETTER SYSTEM OF FOLLOW-UP

In view of the magnitude of the problem involved in the control of nervous and mental disease, it is highly desirable to know the results of treatment. Through continued efforts in evaluating treatment results, we shall increase knowledge for more effective selection and treatment of patients. While follow-up studies provide the means for testing the results of treatment, the methods and techniques for the carrying out of these studies will in a large measure determine the validity and usefulness of the results.

With this in mind, the A. M. I. having inaugurated a follow-up system of letters, which has been described in detail before,[1] requested a student social work thesis on this project to assist in the study and to help discover the most effective methods and techniques of approaching the subject.

A. Analysis of the Follow-Up System by Letters

According to the schedule proposed by the A. M. I. concerning its follow-up system, personalized letters were sent to the patients from the social service department of the hospital. These letters were sent to the patients under study three months after their discharge from the hospital.

When the follow-up system of letters was started at the A. M. I., it was felt that all patients should be advised of

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[1] Supra p. 11

the service before leaving hospital. In this way the patients would be prepared for the receipt of the follow-up letters and would know that it was a routine thing. They would also know what was expected or wanted from them. However, since the patients included in this study were the first to receive follow-up letters after the inauguration of the service and since the staff of the hospital had not become accustomed to the plan, most of the patients had not been prepared for follow-up. While letters sent to the patients explained the purpose of the follow-up, the lack of preparation prior to discharge could reflect in the response of the patients to the letters. This may have been a factor in the lack of response to the follow-up letters.

Fifteen patients, discharged during October, 1949, were seen in follow-up interviews. Of the 15 patients who were interviewed, 13 had been sent follow-up letters. Letters had not been sent to two patients.[1] Of the 13 patients who received follow-up letters, seven patients replied to the letters and six patients failed to reply. This would indicate that the response was a little better than half of the patients.

In addition to the response to the follow-up letters, the writer was interested in what the letters revealed regarding the adjustment of the patients. The method of comparing admis-

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[1] Supra p. 12

sion status with follow-up status and condition at time of follow-up relative to a normal adjustment is, therefore, as outlined in Chapter I.[1] Since the replies to the follow-up letters did not provide sufficient information concerning the social adjustment of the patients, no attempt will be made to compare the social adjustment of the patients.

Of the seven patients who replied to the follow-up letters we learned that six persons were better compared with their condition on admission to hospital, one was the same and none was worse than when he was admitted to hospital.

One of the patients indicated in his reply to the follow-up letter that he was better than when he was admitted to hospital. At the time of his admission to hospital his main complaints were, poor sleep, loss of interest in everything and increasing preoccupation. These complaints had become increasingly more severe over a six month period prior to hospitalization. His diagnosis was schizophrenia with depression. In his reply to the follow-up letter, this patient stated that he was happy to report that he was getting along alright. His work was satisfactory and he had moved to a better location which had added considerably to his well being.

One patient was found to be the same at follow-up as compared to her condition on admission to hospital. When admitted

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[1] Supra p. 9

to hospital her main complaint was anxiety which expressed itself in fears. She also had an overwhelming desire to sleep, proceeded by a feeling of pressure which went up the back of her neck. She had made a suicidal attempt but she did not carry it through. The diagnosis was conversion hysteria. In her reply to the follow-up letter, this patient stated that she was still sick. She could not relax nor make a decision and she felt confused.

In comparing the follow-up condition of the patients relative to a normal adjustment as gained from the replies to the follow-up letters, it was found that one patient was making a normal adjustment, two patients an adequate adjustment, two patients a poor adjustment and two patients were not adjusting. This would indicate that three patients were making a satisfactory adjustment at the time of follow-up and four patients were making an unsatisfactory adjustment. In other words, the greater number of patients were making an unsatisfactory adjustment. This would suggest that the follow-up system by letter gives a poorer indication of treatment results at the A. M. I. than the interview method of follow-up. It would further indicate that the patients making an unsatisfactory adjustment were more likely to respond to the follow-up letters than the patients making a satisfactory adjustment.

One patient, who was making a satisfactory adjustment, complained of feelings of depression and inadequacy on admis-

sion to the hospital. She had trouble sleeping, felt tired all the time, and she was unable to do her housework prior to admission to hospital. The diagnosis was paranoid development in an unstable individual who had shown considerable dependency and some early reactive depression. In her reply to the follow-up letter this patient stated, "I have learned so much from the psychotherapy that I have new confidence in myself, have lost most of my fears, got rid of self-pity, bitterness, resentment, tension, irritability and feelings of inferiority . . . and feel able to cope with almost any situation." She had also been able to do her housework without difficulty.

One of the patients, who was making an unsatisfactory adjustment, complained on admission to hospital of feelings of depression, fears of insanity, suspicions of people talking about him, and loss of appetite and sleep. These complaints had become increasingly more severe over an eight month period although he had felt insecure since at least 1945. He had been unable to work for several weeks prior to admission to hospital. The diagnosis was paranoid state with marked depressive trends. In his reply to the follow-up letter, this patient stated that he was feeling much better but he still had periods of tension and depression and he found it difficult to get away from his world of fantasy. Although he still had some physical complaints, he did not have as much concern about his physical health as he had prior to

hospitalization. He still felt insecure but he found that manual work helped him to regain confidence in himself. In this connection he was doing leather work. Also, he was living with a group of theatrical people and he helped in the making of stage settings and odd chores about the house. He had not returned to his work and he stated that he did not feel so inclined.

B. Analysis of the Follow-Up System by Interviews

The method of follow-up chosen by the writer was that of interviews with the patients. The appointments for interviews were arranged by telephone in nine cases and by a second letter[1] in six cases. Appointments were arranged by telephone with those patients who replied to the first follow-up letter. After consultation with the doctors who had treated the patients while they were in hospital, appointments were arranged by telephone in four further cases. The reasons for this method of approach was previously explained.[2] The second follow-up letter was sent to the remaining six patients. It indicated an understanding by the hospital personnel of the ex-patients' difficulty in answering a letter. It suggested that an interview might be easier, and it gave an appointment

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[1] Appendix, p. 124.

[2] Supra, p. 13.

The case illustrating better at follow-up[1] compared with his admission status, as gained from his reply to the follow-up letter, stated that he was feeling much better when interviewed. He was sleeping well, eating well, and he had gained considerable weight. His only complaint was that he did not seem to have the same energy that he had before his illness. When interviewed, therefore, this patient indicated, as he had in his letter, that he was better than on admission to the hospital.

The one patient illustrating "the same" at follow-up[2] compared with her admission status, as gained from her reply to the follow-up letter, was found to be "better" when she was interviewed. She stated that she could not make decisions, she was confused and she felt nervous and tense all the time. She still had numerous physical complaints but these, she said, were not as severe as before hospitalization. Her fears and overwhelming desire to sleep were not as severe as before admission to hospital. While this patient still felt sick at the time she was interviewed, she felt better than before her hospitalization. This difference noted in the two methods of follow-up seemed to be due to lack of sufficient information

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[1] Supra, p. 96.

[2] Supra, p. 96.

in the letter rather than any actual change in the patient's condition in the interim period.

It was found that the level of adjustment for each of the patients, when interviewed, was the same as was indicated from the replies to the follow-up letters. Three patients were making a satisfactory adjustment and four patients were making an unsatisfactory adjustment. This would suggest that the letters indicated results comparable to that gained from the follow-up interviews in determining the level of adjustment of the patients at follow-up.

The patient illustrating satisfactory adjustment at follow-up[1] as gained from her reply to the follow-up letter, was found to be making a satisfactory adjustment when interviewed. She stated that she was feeling better than at any time in her life. She complained only of a slight difficulty with her sleep. With follow-up psychotherapy she had gradually gained insight. She realized that her whole family were sick and she had been able to detach herself from them. She realized that she used to be a doormat but she felt that she could now stand up for herself. She has been able to carry on her household duties and social activities with ease.

The patient illustrating unsatisfactory adjustment at

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[1] Supra, p. 97.

follow-up[1] as gained from his reply to the follow-up letter, was found to be making an unsatisfactory adjustment when interviewed. When interviewed, this patient felt that he was much better than he was before hospitalization but he realized that he had a long way to go yet. He still had periods of depression and some suspiciousness of people but neither were as severe as before treatment. He had never been able to form a close relationship with anyone. Since his discharge from hospital, he had been living with a group of theatrical people. He kept busy with work on stage props and chores about the house. In working together with this group of people he has been able to form closer relationships than at any time in his life. He felt that this group of people were really interested in him and this had meant a great deal to him. He was not interested in returning to his profession at the time of follow-up.

C. Analysis of the Lack of Response to the Follow-up Letters

Six patients failed to reply to the follow-up letters. These six patients, when interviewed, brought up their lack of response spontaneously and indicated various reasons for not replying. Two patients said that they had tried to reply but they found it difficult to express their feelings on paper. One of these said that her attempts at writing ended up in

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[1] Supra, p. 98.

such a tale of woe that it did not express her gratitude for the help she had received. This patient was not making a satisfactory adjustment and she wanted further help. She was fearful of being rejected by the hospital if she presented a negative picture of her adjustment. The other patient who had difficulty in writing was hostile toward the hospital and the lack of reply was an expression of this hostility. Two other patients indicated hostility toward the hospital in connection with their lack of response to follow-up letters. Of these, one wanted to forget about her illness and the terrible experience in the hospital. The other patient was antagonistic toward the hospital because she had been hospitalized for medical reasons following discharge from the A. M. I. and felt that her case had been mishandled at the A. M. I. She had wanted to write a nasty letter but decided it would do no good and had not answered the letter. The remaining two patients who did not reply to follow-up letters had difficulties at the time the letters arrived and did not get the letters answered. Of these, one patient was ill at the time he received the letter and had been unable to answer it. In the other case, financial worries had diverted the patient's attention at the time the letter arrived.

The reasons for lack of response to follow-up letters would appear to be fear of rejection by the hospital in one

case, hostility to the hospital in three cases, and special problems at the time of receipt of follow-up letters in two cases.

Dr. Rogers says, "In any counseling which is more than superficial, the client is likely to indicate, by one mode of expression or another, either positive or negative feelings toward the counselor and the counseling situation . . . These expressions are directed . . . toward the counseling experience, in terms of the pain or satisfaction which it is at the moment giving to the client."[1] With the recognition that all patients have either positive or negative feelings toward their treatment experience depending on the resulting satisfaction or lack of satisfaction, we shall consider the attitudes of the patients at the time of follow-up and how this affected the response to the follow-up letters.

From Table XX it can be seen that of the 15 patients interviewed four to seven months after discharge from the hospital, 11 patients indicated a positive attitude toward treatment and the hospital. Four patients indicated negative attitudes toward the whole experience. Of the 11 patients with positive attitudes toward the hospital, seven replied to follow-up letters, three patients did not reply, and one

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[1] Rogers, C. R., "Counseling and Psychotherapy", Cambridge, Mass., 1942.

patient did not receive a follow-up letter. Of the four patients with negative attitudes toward the hospital, three patients did not reply to follow-up letters and one did not receive a follow-up letter. All of the patients who replied to follow-up letters had a positive attitude toward the hospital.

Table XX - Response of the 15 Patients to Follow-up Letters Classified According to Level of Adjustment and Attitude Toward the Hospital.

RESPONSE TO LETTERS		SATISFACTORY ADJUSTMENT			UNSATISFACTORY ADJUSTMENT		
			ATTITUDE TO HOSPITAL		ATTITUDE TO HOSPITAL		
	TOTAL	TOTAL	POSITIVE	NEGATIVE	TOTAL	POSITIVE	NEGATIVE
TOTAL	15	9	6	3	6	5	1
REPLIED	7	3	3	-	4	4	-
NO REPLY	6	5	2	3	1	1	-
NO LETTER SENT	2	1	1	-	1	-	1

This would indicate that the majority of the patients with a positive attitude toward the hospital replied to follow-up letters, whereas none of the patients with a negative attitude replied to the letters. This would suggest that the attitude of the patients toward their hospital experience was an important factor in the lack of response to follow-up letters.

When interviewed the majority of the patients were anxious

to talk about their hospital experience and were encouraged by the writer to express their ideas of the experiences which to them had been helpful or disturbing. To what did they attribute success or failure in treatment?

The positive things which the patients mentioned and to which they attributed improvement in their condition are as follows: Five patients stressed the atmosphere of the hospital as being the all important factor in their improvement. The environment was free, enabling one to feel as he liked. One patient explained, "If I felt like being mad, I could be mad." It was a relaxing atmosphere which enabled one to forget about his problems. One patient, in speaking of the relaxed atmosphere said, "It was like being a piece of washed linen, all crinkled up, and the hospital ironed and smoothed it out." The importance of this accepting atmosphere is an important factor in hospital treatment. This has been well expressed by Dr. Simon and Miss Chevlin,[1]

> Many patients obtain considerable relief by coming to a hospital and being removed from disturbing and conflicting home or work situations. Domestic discord and frustrations are diminished in an atmosphere of sympathetic understanding in which the patient may express his difficulties without fear of retaliation. He may show his hostility, his craving for security, his suspicions, or his desire to belong to a group, and is permitted to act out his feelings. He soon becomes con-

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[1] Simon, W. and Chevlin, M. R., "Brief Psychotherapy - A Hospital Program with Participation of the Social Worker," Mental Hygiene, July, 1949, Vol. XXXIII, No. 3.

> vinced that he is but one of many persons with similar emotional adjustment problems. This identification minimizes the need of feelings of inadequacy and inferiority, isolation, face-saving devices, and projections, and creates a favorable background for intensive brief psychotherapy.

Four patients spoke of the recreational activities as being important factors in their recovery and four patients mentioned the staff. The latter were considered by these patients to have been helpful through their friendly attitude. They felt they were always helpful and never appeared too busy to do things for them. One patient felt the hospital was efficiently and well run. Another patient said he had been helped by seeing other patients with different conditions. One patient felt that he had been helped by the group sessions, and in one case the patient felt she owed a great deal to her therapist.

The fact that the majority of the patients had a positive attitude toward the whole hospital experience would suggest that the A. M. I. had effectively established an atmosphere of sympathetic understanding which paved the way for therapeutic measures.

The negative factors about the hospital experience were numerous, with no two patients indicating similar factors. One patient felt that the hospital had been slow in getting started on treatment. Another considered psychotherapy a terrible experience. She stated, "They should never try to

get one to talk about the unconscious." One patient felt the movies should never be shown to the patients because they were so upsetting. One patient felt that everything in the hospital was experimental with young internes who lacked experience and could, therefore, never understand or be interested in what the patients were going through. One patient felt the hospital staff members were not thorough in their examinations and that they overlooked organic causes of the illness. The cost of hospitalization and lack of understanding of what this meant to the patient was mentioned in one case. Another patient objected to the volunteers coming in with their "forced cheerfulness and attitude of 'here I am to help you'."

It is recognized that these negative factors undoubtedly hold some meaning for the individual patient. However, it could be considered as a denial of their illness. As Anna Freud so well expresses this, " . . . the infantile ego . . . gets rid of unwelcome facts by denying them . . . It utilizes all manner of external objects in dramatizing its reversal of real situations."[1] The patients' negative attitudes might be interpreted to be a denial of the real situation and of their illness specifically.

In summary, seven out of 13 patients replied to the

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[1] Freud, A., "The Ego and the Mechanism of Defense," N. Y., 1946.

follow-up letters, whereas 15 out of 16 patients responded to the interview method of follow-up. In other words, the patients responded better to the interview method of follow-up than they did to the follow-up letters.

It was found that the letters did not provide sufficient information concerning the social adjustment of the patients. However, the letters indicated results comparable to that gained from the follow-up interviews in determining the patients' adjustment at follow-up relative to their adjustment on admission to hospital and to a normal adjustment. It was found that only three out of the seven patients who replied to the follow-up letters were making a satisfactory adjustment. This indicated a poorer level of treatment results at the A. M. I. than the interview method of follow-up.

The lack of response to the follow-up letters appeared to be the main factor in providing a poorer indication of treatment results than the interview method. The writer, therefore, considered some factors which may have effected the patients' lack of response to the letters. It was felt that the lack of preparation of the patients for the follow-up letters may have been one factor. The added pressure of attempting to write a letter about themselves, when they already felt insecure, may have been too great to expect from the patients. Another factor in the lack of response appeared

to be the attitude of the patients toward the hospital. It was found that the greater number of the patients with a positive attitude toward the hospital, replied to the letters, whereas none of the patients with a negative attitude replied to the letters. This would suggest that the attitude of the patients toward their hospital experience was an important factor in their response to the follow-up letters.

The fact that the majority of the patients had a positive attitude toward hospitalization would suggest that the A. M. I. had effectively established a sympathetic and understanding atmosphere in the hospital which paved the way for effective treatment. On the other hand, the negative attitudes of some of the patients appeared to be a denial by the patients of the real situation and more specifically of their illness.

CHAPTER SEVEN

CONCLUSIONS

This study set out to describe the follow-up adjustment of 15 patients compared with their adjustment on admission to the Allan Memorial Institute of Psychiatry and relative to a normal adjustment. The aim in describing the adjustment was to see whether the A. M. I. was successful in its goal of returning a better functioning individual to the community. A further, but minor emphasis of the study was a consideration of the method of follow-up. In this connection the writer's choice of follow-up interviews provided a basis for comparing methods of follow-up, and for indicating the effectiveness of the follow-up system of letters at the A. M. I.

The findings of this study will be considered in relation to the three basic questions the writer has attempted to answer.

A. How does the status of the patients on admission differ from their status approximately four to seven months after discharge?

It was originally planned that the writer would attempt to answer this question with respect to symptomatology, family, friends, work, and recreation. However, the hospital records did not provide sufficient information regarding the social adjustment of the patients on admission to hospital and the

analysis could only be done with respect to symptomatology and family.

Concerning the symptomatic adjustment of the patients it was found that all of the patients but one were better than when they were admitted to the hospital. In this one case the adjustment was the same on follow-up as when he was admitted to the hospital. Concerning the adjustment in family living, all but three patients were making a better adjustment at the time of follow-up than they were when they were admitted to hospital. These three patients were the same in their family living as when they were admitted to the hospital. This would suggest that the majority of the fifteen patients studied were making a better adjustment with respect to symptoms and family living than on their admission to hospital. Slightly more patients were helped in the alleviation of symptoms than in family living. This could be significant but, with the small number of cases, it could not be conclusive. This difference might be significant in view of the fact that the social service department of the A. M. I. was not active in social admission nor treatment during the period of hospitalization for this group of patients. A further study of patients who had had casework services would be useful in providing further data on social adjustment.

B. How is the patient functioning now in relation to what is considered normal?

In this connection it was found that the greater number of the patients were making a satisfactory adjustment, both in the alleviation of symptoms and in the four areas of their social life. This would suggest that the A. M. I. had been effective in returning the larger number of the patients to the community as better functioning individuals. The number of patients functioning satisfactorily was consistently smaller for the social adjustment with respect to friends, work, and recreation than for the symptomatic and family adjustment. Again, it is possible that the lack of social casework services for this group of patients could have been a factor in the somewhat lower level of social adjustment of the patients.

Some aspects which may have played a role in treatment results were evaluated in each of the areas of rehabilitation. These aspects were: diagnosis, further treatment following discharge from the hospital, and recommendation on discharge and its being carried out.

With respect to diagnosis, it was found that the neurotic patients received greater benefit in all areas of their adjustment than the psychotic patients. Dr. Hunt in surveying the literature of results of psychiatric treatment with respect to diagnostic groups states:

> A review of therapeutic statistics in psychiatry shows that the rate of melioration in the psychoneuroses at the time of discharge is higher than in the psychoses.

> On the other hand, the rates for the psychoses in the follow-up reports for five-year periods . . . compare favorably with follow-up rates for the psychoneuroses . . .[1]

Dr. Hunt's findings would serve to emphasize the importance of long term follow-up studies in any attempt to determine the effectiveness of psychiatric treatment.

It was found that psychiatric treatment following discharge from the hospital seemed to have been a factor in effecting a satisfactory adjustment. In all areas of the patients' adjustment it was seen that the greater number of patients who had follow-up psychiatric treatment were making a satisfactory adjustment, while the greater number of those patients having medical treatment or no treatment following discharge were not adjusting satisfactorily. Similar results were found in the carrying out of discharge plans. The majority of the patients who carried out discharge plans were making a satisfactory adjustment while the majority of those who ignored discharge plans were making an unsatisfactory adjustment.

While this study would tend to show that these aspects seemed to indicate effectiveness of treatment, a further study in this area might offer some answers to the significance of the role they played in treatment results.

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[1] Hunt, J. McV., "Personality and the Behavior Disorders", Vol. II, N. Y., 1944.

C. How useful is the follow-up letter system as a means of indicating the effectiveness of treatment at the A. M. I.?

This study indicated that the follow-up letter system was not as effective in showing treatment results for all the patients discharged from the hospital as was the interview method of follow-up. This was shown to be largely due to the fact that the patients, as a whole, did not respond to the follow-up letters as well as they did to the interviews.

It was found that the letters did provide an indication of the individual patient's level of adjustment at follow-up comparable to that gained from the interviews. Because fewer than half of the patients who replied were not adjusting satisfactorily, the indications of effectiveness of treatment at the A. M. I. was not so good as the interview system.

Since the lack of response to the follow-up letters seemed to be the important factor in providing a poorer indication of treatment results than did the interview method of follow-up, an analysis was made of the lack of response to the letters. It was felt that the lack of preparation of the patients for the follow-up letters may have been a factor. A further factor in the lack of response to the follow-up letters was the difficulty the patients experienced in replying to these letters.

The difficulties experienced by the patients in writing were varied but it would seem that the added pressure of letter writing was too great to expect from many patients who were

not too secure in themselves. On the other hand, the interview method provided an opportunity to give support and interpretation of follow-up.

The attitude of the patients toward the hospital was also an important factor influencing response to follow-up letters. The majority of the patients with a positive attitude toward the hospital replied to the letters, whereas none of the patients with a negative attitude replied. It was found that those patients with a negative attitude toward the hospital were denying their illness and did not want to talk about their breakdown. Those patients with a positive attitude were the majority of the patients. This would suggest that the A. M. I. had been successful in establishing a sympathetic and understanding atmosphere in the hospital which paved the way for effective treatment.

APPENDIX

September 23rd, 1949.

MEMO TO: Dr. E. L. Margetts
Dr. N. B. Epstein
Mrs. P. Poland

FROM: Dr. D. Ewen Cameron

At our recent meeting concerning the setting up of a follow-up system for the Allan Memorial Institute, the following points were agreed upon:-

1. All patients will be told before they leave that we will try to keep in touch with them and the details of this will be explained to them.

2. A follow-up letter will be sent to the patient.

3. Follow-up at the end of 3 months, 6 months, 1 year, 2 years, 3 years, etc.

4. The follow-up letter will be signed by myself, but will be composed by a social worker who will be able to consult with one of the assistant residents concerning the contents of the letter.

5. The Letter should be personalized and should be based upon the discharge summary.

6. The matter of classifying the replies will have to be worked out as we proceed. The classification, however, should certainly contain the following categories:-

   a) Well.
   b) Requires ambulant therapy.
   c) Had to return to hospital.
   d) Occupational history.
   e) Domestic history.

   There should be a cross-classification with types of illness and perhaps types of treatment.

7. It is understood that this service will be initiated on October 1st, 1949, Mrs. Poland undertaking to assign a social worker to the job.

APPENDIX

MEMO (continued)

8. Prior to this the resident staff will be informed of the service and requested to inform each patient being discharged after October 1st that follow-up letters will be sent. Follow-up letters will not be sent to patients discharged prior to October 1st, 1949.

9. The follow-up letter should contain a return envelope marked "Attention Follow-up Service."

D. Ewen Cameron, M. D.
Director

APPENDIX

MEMO

13th January, 1950.

Dr. D. Ewen Cameron — Dr. C. H. Cahn

REPORT OF MEETING ON FOLLOW-UP.

PRESENT: Mrs. Poland, Miss Lawrence, Miss McMurty, Dr. Cahn.

At this meeting we discussed the Follow-Up programme as outlined by your memo of September 23rd, 1949, and we reached the following conclusions:

AIMS.

Mrs. Poland and I will work out the follow-up letters to be sent to patients who were discharged from the A. M. I. after October 1st, 1949.

Miss Lawrence is preparing an M. S. W. thesis and wishes to interview those patients living in the Montreal area who were discharged in October, 1949.

Miss McMurty wishes to follow-up D. P.'s and will work in conjunction with Dr. L. Tyhurst.

METHOD.

A. Steps to be taken before the letters are written:
   1. Consideration of Discharge Summary and other relevant case record material.
   2. Discussion with interne who was or still is looking after the patient concerned.
   3. Possible contacting of other persons who are associated with patients, e. g. certain doctors, social workers, relatives, etc.

B. Composing the letters.

Each letter would contain a short explanatory introduction, and two main parts for the patients to attend to:

APPENDIX

MEMO (continued).

(i) General questions, addressed to All patients such as: "How did you feel before you came to the Allan? How after discharge? How do you feel now? What is your outlook for the near future? Have you any important problems to deal with?" (This is to be worked out).
(ii) Particular questions directed to patients with regard to their own problems, based on information gathered from A. 1, 2, 3, above.

The wording of the letter would have to be considered carefully so that patients would not be antagonized or frightened by the letter.

C. Evaluation of replies received.
We have not yet worked out the best scales of classification of patients' conditions but we prefer the following two general scales:

(i)
1. Complete recovery.
2. Social recovery including operation.
3. Improved but unoccupied.
4. Unimproved.
5. Deteriorated.
6. Died.

(ii)
1. Well, not requiring treatment.
2. Requiring ambulent treatment.
3. Requiring hospitalization.
4. Committed.
5. Died.

Sub-classifications will be worked out later. They will include: Diagnoses and treatments employed at A. M. I., other illnesses, hospitalizations and outside treatments, and miscellaneous factors, e. g. duration of stay in A. M. I. and of total treatment, domestic situation, change of domicile, language difficulties, etc.

FURTHER CONSIDERATIONS.

1. Un-co-operative patients.
(a) We felt that initially we should not send letters to patients who have been committed or discharged against advice (I am working on the follow-up of those patients who went to Verdun). Later, perhaps we might send

APPENDIX

MEMO (continued).

(b) Patients who do not reply: we would like to discuss with you and the internes concerned whether any other methods of follow-up such as phone calls, might be feasible.

2. Validation of patients' replied.
We will be most interested to compare patients' replies with other information available on them and study the discrepancies between them. (Miss Lawrence's interviews, and possibly psychological tests which we hope can be organized, will help to evaluate patients' replies).

3. Establishment of Follow-Up Files - to contain discharge summary, follow-up letters, patients' replies and other relevant material - eventually to be integrated with patient's case record.

4. Collection of references to follow-up reports in the literature.

C. H. Cahn, M. D.

APPENDIX

1025 Pine Ave. W.,
January 30th, 1950.

Miss Mary Doe,
123 Newton Ave.,
Newton, Quebec.

Dear Miss Doe:

This is the first of the follow-up letters which we were going to send you after you left us. We would like to ask you how you are getting along. At the time you left our notes show that you were feeling somewhat better. After you left you planned to see a doctor privately.

Could you write to us and let us know how you are feeling? Before you came here you found it difficult to do your housework. While you were here, after you felt better you practised typing. Are you now able to carry out your house hold duties and have you continued with the typing?

When you look back on your stay with us, what do you think you gained from your treatment at the Institute, and what did you find most helpful?

What do you now feel would have made your stay with us more satisfactory and helpful?

We are most anxious to hear from you, both because of the interest of the staff of the Institute in your progress, and because from what we learn about how people who have been with us get along after leaving; we hope to make still further improvements in our methods of treatment.

Yours sincerely,

D. Ewen Cameron, M. D.

DEC:IAP

APPENDIX

1025 Pine Ave. W.,
February 15, 1950.

Miss Mary Doe,
123 Newton Ave.,
Newton, Quebec.

Dear Miss Doe:

We wrote to you recently wondering how you have been getting along since you left the Institute.

As we haven't heard from you we were wondering if you would prefer to have a talk with one of our Social Workers. Miss Lawrence tells me that she could come to see you at . . . . . If this time is not convenient for you, you can get in touch with Miss Lawrence at Pl. 1251, Local 561.

As we explained in our previous letter we are anxious to hear how you are getting along. Also what you can tell us will help us to make further improvements in our treatment.

Sincerely yours,

D. Ewen Cameron, M. D.

DEC:IAP

APPENDIX

DOCUMENT SCHEDULE

Name . . . . . Marital Status . . . . Age . . . Sex . . .

Date Admitted . . Date Discharged . . Previous Admissions . .

Discharge Diagnosis . . . . . Discharge Plans . . . . . .

Condition on Discharge and Prognosis . . . . . .

Progress and Treatment During Hospitalization . . . . . .

Psychological Findings . . . . . Problem on Admission . . .

Family History . . . . . Personal History . . . . .

Diagnosis on Admission . . . . . .

SCHEDULE FOR FOLLOW-UP INTERVIEW

Response to Renewal of Contact . . . . . .

Attitude to Hospital . . . . . .

Appearance, Behaviour, and Attitude During Interview . . .

Social Adjustment Since Last Seen

a) Work Adjustment . . . . . .

b) Hobbies and Recreation. . . . . .

c) Social Adjustment and Friends . . . . . .

Adjustment to Family . . . . . .

Attitude of Family and Friends Toward Hospitalization . .

Treatment Since Leaving Hospital . . . . . .

Present Symptomology and Mechanisms Observed . . . . . .

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